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ABSTRACT

Five agencies of the Public Health Service (PHS) joined with PHS Hispanic employees and other Hispanic health specialists to commemorate Hispanic Heritage Week by critically examining health issues of particular relevance to Hispanics. The first day the forum sought to define, from an Hispanic perspective, issues relating to health statistics, health manpower, health planning, utilization of health care, and health research. Following introductory statements and a keynote address, participants selected attendance at five workshops, where intensive deliberations took place. The workshops examined adequacy of the health care system in meeting needs of the Hispanic population, obstacles to development of Hispanic manpower in the health field, barriers to access and utilization of health services by Hispanics, Hispanic cultural factors in substance abuse and mental health, and some of the problems that must be solved for a more fruitful interaction between the Hispanic community and the National Institutes of Health. The second day was devoted to an overview of Hispanic culture, past and present. The forum closed with a panel discussion among four Hispanics from different geographical regions and orientations, pointing out differences and commonalities. Recommendations cover the five issue areas plus community and migrant health centers. Keynote addresses for each workshop are included, as well as a supporting bibliography of 345 references. (BRR)

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PROCEEDINGS OF

the 1st Annual Forum on the Status of Hispanic Health

WASHINGTON., D. C.

Hispanic Mosaic A Public Health Service Perspective

MARTA SOTOMAYOR
EDITOR

SPONSORED BY
THE PUBLIC HEALTH SERVICE
HISPANIC EMPLOYEE ORGANIZATION
IN COMMEMORATION OF THE
HISPANIC HERITAGE WEEK
OBSERVANCE

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INTRODUCTION

The 1st Annual Forum on the Status of Hispanic Health took place in Rockville, Maryland, and represents the continuing efforts of the Hispanic Employee Organization of the Public Health Service, Department of Health and Human Services, to address the critical health issues affecting the various Hispanic populations in the U.S.

As the numbers of Hispanics in this country continue to grow, primarily due to the in-migration prompted by the severe sociopolitical and socioeconomic conditions presently being experienced in the various countries of origin, their vulnerability increases. It seems so ironic that, like many other ethnic groups in the past, the majority of Hispanics migrate to this country seeking an opportunity for self-sufficiency and self-reliance, yet their dependency on others for survival continues.

Among many factors, lack of resources, discrimination, linguistic and cultural differences, low educational attainment levels, and adjustment to complex and technological urban life contribute to the dependency, not only of recent immigrants but of those whose ancestors have been in this country for centuries. But most importantly, in many overt and covert ways, these conditions are perpetuated by the majority of Federal, State, and local health policymakers, bureaucratic institutions, and processes.

Adequate health care is a political issue, greatly dependent upon the interplay of differing and competing interest groups. Those groups which have access, credibility, acceptability, and visibility--in other words, power--successfully compete for the health care resources and have a greater chance of getting their programs financed and institutionalized. However, Hispanics have not as yet assumed those power behaviors that would allow us to compete successfully in the health care arena. Much to our dismay, as some gains are made, the systems of support which can enable the establishment of appropriate health care and promotion programs for Hispanics are being radically reduced and/or totally eliminated. Such a predicament should be of great concern to health policymakers, planners, providers, educators, and researchers, for this situation demands that more services be provided with less resources. Future decisions will have to be made, guided by clearly articulated policies which are based on a sincere and true concern for vulnerable populations, rather than by decisions negotiated in the marketplace, among people who have the wherewithal to compete equally with one another.

The topics discussed at this Annual Forum are not new, nor have they been resolved, and in all probability they will be with us for many years to come. A tremendous source of encouragement for their resolution lies in the sense of hope, a typical characteristic of Hispanics, that has allowed us to survive through centuries of colonization and exploitation. Additional hope is provided by the commitment and work of the few Hispanics associated with the health care and promotion enterprise, a commitment which is often expressed in a never-ending sense of responsiblity to continue to bring these issues, which apply to other poor populations as well, before Federal policymakers and administrators, as well as before the public in general. This publication, therefore, is most meaningful in this context.

Marta Sotomayor, Ph.D.
Editor
Hispanic Employee Organization

January 1983

PREFACE
Roy G. Martinez
Division of Equal Opportunity
National Institutes of Health
Public Health Service

National Hispanic Heritage Week was first held during September, 1978, according to what has become an early fall tradition, following President Jimmy Carter's proclamation:

> "I call upon all Americans to take this occasion to reflect on the influence of Hispanic culture in our land, and to consider how each of us can be more responsive to the concerns of Hispanics.
>
> "As we observe National Hispanic Heritage Week with appropriate ceremonies and activities, I call upon all Federal, State, and community agencies, all business and professional leaders, educators, the clergy, and the communications media to join with me in launching new Hispanic initiatives that will assure the full participation of Hispanic Americans in every sector of American life, at every level of leadership and guarantee that the human and civil rights of Hispanics, other minorities and, indeed, all citizens of our country are fully protected under the law."

Under the overall theme "Hispanic Mosaic," five agencies of the U.S. Public Health Service (PHS) joined with PHS Hispanic employees and other Hispanic health specialists to commemorate Hispanic Heritage Week. The five agencies that participated are: the Office of the Assistant Secretary for Health (OASH); the Health Resources Administration (HRA); the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); the National Institutes of Health (NIH); and the Health Services Administration (HSA).

The activity was organized by a committee on Hispanic health concerns, chaired at that time by Pedro Morales, and the Hispanic Heritage Public Health Workers, presided by Henrietta Villaescusa, under the auspices of the PHS Social/Cultural Planning Subcommittee from the PHS Office of Equal Employment Opportunity.

Setting the tone for the 2-day event, Pedro Morales opened the ceremonies with the following words:

> "Our theme for this occasion addresses the Hispanic Mosaic. Our logo, used throughout this activity, is symbolic of the mosaic of characteristics, nationalities, and races which comprise the Hispanic population in the United States. Whenever the words "Hispanic" or "Latino" are heard, you should not form in your minds any particular racial and/or color stereotype, for Hispanics are Caucasian, brown, and black.
>
> "Our people are found from Spain to Central, North and South America, and the Caribbean. Some of us are bilingual, some of us are monolingual, in Spanish or English. Hispanic Americans constitute a heterogeneous population. Individuals of Mexican, Cuban, Puerto Rican, South and Central American origin have varying degrees of sociocultural and demographic characteristics. The United States is the fifth largest Spanish-speaking country in the world.

> "Our logo, the "Ñ," symbolizes the commonalities among the different groups of Hispanics in the United States. It is symbolic of our common Spanish ancestry--the language, religion, art, music, and those cultural, sociological, and psychological aspects of our Spanish origin. The logo will continue to serve as an identifier for us, the Hispanics who serve the public through our efforts in the Public Health Service."

For the first time since its inception, the PHS celebration of Hispanic Heritage included a critical examination of health issues that are particularly relevant to the Hispanic population of the United States. Specifically, the 2-day forum sought to define issues, from a Hispanic perspective, relating to the following areas:

- Health statistics
- Health manpower
- Health planning
- Utilization of health care
- Health research

The forum had the task of examining these health issues in the light of each agency's current or contemplated programs, and developing suggestions and recommendations for the future.

The first day of the forum was devoted to an in-depth examination of the five areas mentioned above. Following the introductory statements and a keynote speech setting the general framework for the forum, participants selected for attendance among five workshops, where intensive deliberations took place.

Each workshop participant heard at least one presentation by an expert on the subject; and each workshop had a PHS Hispanic employee as moderator and recorder, as well as a PHS resource person knowledgeable of that subject area.

The workshops examined, among other issues, the adequacy of the health care system in meeting the needs of the Hispanic population, the obstacles to the development of Hispanic manpower in the health field, the barriers to access and utilization of health services by Hispanics, and some of the problems that must be solved for a more fruitful interaction between the Hispanic community and the National Institutes of Health.

After agency representatives' reactions and a dialogue with the audience on each paper, recommendations were made, many of which were directed specifically to the five participating PHS agencies.

The second day was devoted to an overview of Hispanic culture, past and present, in the United States, thus presenting another dimension of the Hispanic experience. Slide/tape presentations of cultural and historical aspects of the various groups were shown.

Appropriately, the forum came to a close with a panel discussion between four Hispanics from different geographical regions and orientations, with the purpose of pointing out differences and commonalities. Each individual focused on special elements that make up the character of his or her respective group. As each spoke, they provided evidence of various aspects which, like the small pieces that make up a mosaic, give life to the larger picture known as the "Hispanic Mosaic"--the Hispanic population--of the United States.

OPENING REMARKS

by Ruth Sanchez-Dirks, Ph.D.
Associate Deputy Director for
Equal Employment Opportunity
Public Health Service

The Hispanic Mosaic consists of over 14 million persons of Spanish ancestry who live in the United States. Some of us have lived in what is now the United States longer than anyone else, with the exception of the American Indian, while some of us are recent arrivals from Cuba, Puerto Rico, Mexico, and Central and South America.[1]

We are young--younger than the U.S. population as a whole. Our numbers are rapidly increasing. About 6 percent of our families have six or more children. By the mid-1980's, the number of Hispanic Americans will be larger than the projected figures for any other minority group.

We are poor. About 20 percent of all our families are living below the poverty level, compared to 11 percent for the total population. Many of us have not had the opportunity of schooling. One out of every five of our adults, 25 years and older, has completed less than five years of school.[2]

We live in every State of the Union, but well over 60 percent of our population live in California, Texas, and New York. Other states with large populations of Hispanics are New Jersey, Illinois, and Florida.[1]

We are more urban than the population as a whole, with nearly 88 percent of us living in urban areas. Yet the U.S. depends on us to a large extent to pick her crops.

Eighty percent of us claim Spanish as our mother tongue, yet only 10 percent are monolingual in Spanish. Others of us do not speak Spanish or do so with English accents.

Lack of adequate housing is a problem for many of us. One-quarter of us live in overcrowded homes.

As you are well aware, the unemployment rate among Hispanics is high--11.4 percent versus 8.1 percent for the general population in 1976. Our largest area of employment is manufacturing, and more than one-fourth of our working males are in white-collar occupations. The proportion of Hispanic men in the labor force is about 78 percent, and about 38 percent for our women.[2]

In brief, we are young, poor, multiplying in number, dispersed throughout the country, multiethnic, urban, bilingual, bicultural, blue-collar workers, and proud of our heritage.

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[1] Bureau of the Census, "Persons of Spanish Origin by State: 1980." U.S. Department of Commerce, August 1982.

[2] Bureau of the Census, "Persons of Spanish Origin in the United States: March 1976." U.S. Department of Commerce, July 1977.

Health Status

It is most difficult to present an accurate picture of the health status of Hispanic Americans, as, until the passage of P.L. 94-311 in June, 1976, Hispanics were classified as white in the collection of vital statistics. Inclusion of Hispanics in the white category results in higher mortality and morbidity rates as compared to the white category without Hispanics.

In 1975 health interviews, families with lowest incomes were five times more likely than families with highest incomes to judge their health as only fair or poor. Hispanics tend to have low incomes.

We know that life expectancy among whites increases with educational level. Hispanics have high dropout rates and low academic achievement. The South, which has the highest percentage of poverty and minority populations, has the lowest life expectancy rate.

Data for 1950 and 1960 indicated that Hispanics had higher mortality rates than whites but not as high as blacks. Death certificates, as the source of national mortality statistics, do not permit classification of mortality by the five principal ethnic groups. Persons of Hispanic origin are not classified separately in the vital statistics categories; but if this were done, some would be included with "black" and some with "white." Thus, it is at present impossible to tabulate the number or rates of death separately for the Hispanic population or to tabulate blacks or whites excluding Hispanics. It is expected that by the end of 1978, Hispanic coding will be possible for 18 to 20 States.

The same problem of identification exists in the examination of birth certificates in determining mortality statistics. Infant mortality rate is 50 percent higher for residents of poverty areas than for those of nonpoverty areas. On the socioeconomic measures of income and education, the lowest income group had a 50 percent higher infant mortality rate than the highest income group; and the difference is even greater between the least and most educated.

While the classification of Hispanic individuals into a "Hispanic" category solves the problem of separating the Hispanics from the whites and blacks, it does not solve the problem of differentiation among the various Hispanic ethnic groups. A general Hispanic classification, therefore, could conceal differences that may exist among Hispanics of different ethnic origins.

Estimating the utilization of health services is again difficult, as much of the data is not broken down for Hispanics. We know that the poor delay seeing physicians until their health problems become more serious. The poor below the poverty line utilize services less than those above the poverty line. In 1970, low-income women who received prenatal care during the first trimester of pregnancy constituted only three-fourths of the percentage of middle- and high-income women who received such care. There were three times more poverty area residents than nonpoverty area residents who did not have any prenatal care.

As we know, black doctors serve mostly black patients and non-black doctors serve mostly white patients. Where then do Hispanics go for medical treatment when only 1.9 percent of the total enrollment of medical schools are Hispanic? Only 19.3 percent of neighborhood health center registrants are Hispanic. On the average, whites have a 15 percent higher admission rate to mental hospitals than Hispanics. In closer examination, however, we find that the rates for our Hispanic youth between the ages of 14-24 and for our Hispanic elderly 65 years and older are nearly double the rates for whites. In terms of admission to mental hospitals, the rate for our elderly, who are culturally very precious to us, is higher not only than the rate for whites but for all other racial minorities.

In the consideration of health manpower, we find that Hispanics are underrepresented in relation to our number in the general population, in the enrollment in all health professional schools. Even in the fields of medicine and dentistry, which have the highest proportions of minority students among the health professions, Hispanics constitute only 1.9 and 1.3 percent of the total enrollment, respectively. We fare a little better among dental laboratory technicians and radiation technicians, where Hispanics constitute 3.2 and 2.4 percent of the total enrollments.[3]

Issues

In spite of our limited statistics, we know that the existing health care services are not effectively serving the Hispanic population.

One of the reasons why Hispanics receive less effective services is simply that agencies lack personnel capable of communicating with us. On every level of a patient's transaction with the public agency, patients are delayed or denied services if they do not speak English. Agency personnel often feel that they are working harder for the Hispanic patient than for those patients who speak English, since, for example, an interview sometimes takes twice the time it does in the case of other patients. Moreover, there is little social work followup, continuity of care, health education, and, specifically, preventive education being performed.

Comprehensive health services programs are generally less helpful to Hispanics than to the rest of America's poor. There are a variety of cultural, legal, and linguistic reasons for this. First, Hispanic males are often reluctant to seek public help because of their pride, customs, traditions, and social attitudes. Furthermore, Hispanics, especially those coming from a folk culture, are accustomed to solving their own problems without seeking outside help. Many are denied benefits of various social programs because they are aliens, while many more cannot meet local residency requirements. Most Hispanics employed in agriculture are excluded from coverage by unemployment insurance, industrial accident insurance, and other Social Security benefits. In addition, those Hispanics under Social Security programs often fail to benefit from them because of their unfamiliarity with claims procedures. Social Security claims, benefits, and private insurance coverge, as well, are less utilized by the Hispanics in general than by the population at large. Greater involvement in health planning and consumer information programs would serve to improve the available health services and their utilization.[4]

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[3] Health Resources Administration, "Health of the Disadvantaged, Chart Book." September 1977.

Many Americans of Spanish background have persistent English language difficulties, with the effect of deepening and prolonging their cultural isolation from the mainstream of the population. Mechanisms for reducing this isolation through communication across ethnic lines in both the job market and other aspects of economic and social life, including comprehensive health service, have been generally inadequate.

To these difficulties must be added that of inadequate education among both Mexican Americans and Puerto Ricans, especially in the older age groups. A lack of education combined with a limited knowledge of English further compound the obstacles to satisfactory, well-paid employment for many Spanish-speaking adults.[5]

A major area of concern to the Public Health Service must be the underemployment of Hispanics within its ranks. It is the firm belief among PHS Hispanic employees and Hispanic communities that when Hispanics are not adequately involved at all levels of the Federal health care system, from policymaking to patient contact, the quantity and quality of health care provided to Hispanics is much lower than that provided to the rest of the American public.

In December, 1976, the Public Health Service employed 434 Hispanics, or 1.2 percent of the total employees. This is 5.1 percent less than the representation of Hispanics in the general American population. The proportion of Hispanics employed in HHS as of September 30, 1981, was 1.7% of PHS employees, or 842 Hispanics--a 0.5 percentage increase from 1976 figures. Hispanics are the only minority group that are not overrepresented, in relation to their presence in the population, in the whole range of Public Health Service employment.

In addition to the issues already mentioned, I would suggest keeping in mind the following ones:

- The lack of research into the health needs, characteristics, treatment modalities, similarities and dissimilarities of the Hispanic researchers who are sensitive to the Hispanic culture.
- The lack of training received by health professionals on Hispanic culture, its importance in dealing with Hispanic patients and self-awareness as to their attitudes toward Hispanic Americans.

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[4] "Position Statement on Health Issues Concerning the Spanish-Speaking Spanish Surnamed Population of the United States," unpublished document prepared by the Spanish Speaking Public Health Service Workers Organization, January, 1974.

[5] Ibid.

[6] "Position Paper," unpublished document prepared by the Spanish Heritage Public Health Service Workers, December 22, 1977.

-- The misdiagnosis and overhospitalization of Hispanics by non-Hispanic professionals.

-- The importance of targeting health and prevention services to our young people, who are increasing in number and most vulnerable.

-- The small number of programs directed specifically towards Hispanics, and the methods of changing existing services to meet the bilingual, bicultural characteristics of Hispanics.

-- The severe shortage of Hispanic health manpower not only in the delivery of services but in policymaking positions on the local, State, and Federal levels.

-- The examination of Anglo-designed treatment modalities and their appropriateness to the Hispanic population.

-- The utilization of folk healers in the established health care systems, when, where and if appropriate.

-- The overgeneralization and stereotyping of Hispanics by health care professionals as irresponsible, impulsive, unintelligent, and untreatable.

-- The continued need for the collection of Spanish specific health data as required by P.L. 94-311, as well as data classified according to Hispanic ethnic groups. The Hispanic HANES is a first step in this direction.

-- Recognition of the great economic poverty among the Hispanic population, and its influence on the delivery of health services; such as, inaccessibility, inability to carry out doctor's instructions with regard to medication and diet, the hesitancy to question the physician, and others.

-- The effects of acculturation on Hispanics, especially our youth who may need help in developing strong self-image coping skills, and the provision of strong Hispanic role models.

The issues are many, the solutions vary according to complexity; but I believe that, if the Public Health Service would make a true commitment to improve the health status of Hispanic Americans, we could go a long way in improving the health status of more than 14 million Americans.

KEYNOTE SPEECH

"Problems in Providing Adequate Health Care to Hispanic Populations"

Carlos Vallbona, M.D.
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Acknowledgment is given to Amelie G. Ramirez, M.P.H., and G. Ken Goodrick, Ph.D., for their assistance in the preparation of this paper.

"Problems in Providing Adequate Health Care to Hispanic Populations"
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INTRODUCTION

Numerous reports on the adequacy of the American health care system have concluded that the health care needs of the Hispanic minority are not satisfactorily met by the system. A basic argument is that it is the outcome of the fact that most Hispanics are in the lower socioeconomic strata. But apart from socioeconomic considerations, it is important to analyze certain aspects of the accessibility, quality, and cost of health services, as well as the health beliefs, attitudes, and practices of some members of the Hispanic community. All these factors influence the outcome of community health programs targeted to Hispanics.

The scope of the problem of providing health care to Hispanics is increasing rapidly. The Hispanic population is growing 6.5 times faster than the general population (Guernica and Kasperuk, 1982). Hispanics currently total 15 million people (U.S. Department of Commerce, 1981). By 1990, Hispanics may comprise 20 percent of all U.S. residents (Guernica and Kasperuk, 1982). Demographically, Hispanics differ considerably from the average American. Their median age, income, and educational levels are lower (Guernica and Kasperuk, 1982). They have larger families, many of which have maintained their Spanish language, and are predominantly Roman Catholic (Guernica and Kasperuk, 1982). Most Hispanics live in cities in a geographically concentrated area of nine States, and the trend is for further urbanization (Guernica, 1980). Beyond these general characteristics, it should be recognized that the Hispanic population is composed of a mosaic of distinct ethnic groups.

Persons of Mexican origin. As of 1978, 59 percent of all Hispanics belonged to this group (U.S. Department of Health and Human Services, 1980). They are descendants of persons who lived in the southwestern part of the United States which had previously belonged to Mexico. They have retained the Spanish language and some aspects of the traditional Mexican culture. In some instances they are descendants of marriages between Spaniards and American Indians. A degree of acculturation has taken place in this group, especially among second and third generations and even more so among those who have higher educational levels and who earn comfortable incomes. A sizeable number of individuals in this group are more recent immigrants from Mexico who are in the process of learning English and accustomed to the American way of life.

Persons of Puerto Rican origin. As of 1978, 15 percent of all Hispanics living in the United States (over 2 million) were persons of Puerto Rican origin, while nearly 3 million Puerto Ricans live on their native island (U.S. Department of Health and Human Services, 1980). Although a significant number are descendants of Spaniards or other Europeans who emigrated to Puerto Rico, there is a high proportion of descendants of mixed marriages between Europeans and persons of African origin who had been brought to Puerto Rico as slaves. All of them use the Spanish language and hold on to the Latin American culture, with distinct African influences which are quite noticeable throughout the island of Puerto Rico.

Persons of Central and South American origin. They comprise approximately 800,000 individuals. By and large, they are descendants of Spaniards or other Europeans (Italian, German, and British) who emigrated to Latin America and who either preserved or acquired the Spanish language and the Latin American culture. Strictly speaking, only the descendants of Spaniards should be classified as Hispanic because of their Spanish surname, but from a cultural standpoint, they are all Latin American. Depending on the country of origin, the ratio between Europeans and descendants of marriages between Europeans and native Indians is quite variable. Some populations of countries like Argentina have practially no Indian Heritage, and other countries like Peru have a high proportion of persons of Indian heritage. In the last 5 years there has been an increase in the number of immigrants from Central America, mainly from El Salvador, Nicaragua, and Guatemala. In general, they are of mixed European-Indian origin. They belong to low socioeconomic groups, and their health beliefs are more similar to those of Mexican Americans than of Hispanics of European origin.

Persons of other Spanish origin. Approximately 1 million persons are included in this group. Some of them may be immigrants or descendants of immigrants from Spain, but their number is much lower than 1 million.

Persons of Cuban origin. Their number has been estimated in excess of 700,000 (U.S. Department of Health and Human Services, 1980). They are descendants of Spaniards or other Europeans who emigrated to the island of Cuba. Among Cuban Americans there is a relatively small percentage of descendants of marriages between Europeans and African slaves who were brought to that island. Since Cubans are relatively recent immigrants, their primary language is Spanish; they hold on strongly to their Cuban heritage. A high percentage who emigrated to this country in the sixties were members of the upper and middle classes of Cuba. They have high educational levels and a good command of English, and their socioeconomic status (SES) is quite good. Cubans who emigrated in the 1980's belong to a low socioeconomic group. Many of them are descendants of mixed European-African progeny.

From the standpoint of health care of those most in need, the groups that require special consideration are those of low-income Mexican or Puerto Rican origin. Because of their socioeconomic status, their health beliefs, and their attitudes toward and access to the health care system, they must be studied apart from those Hispanics of higher socioeconomic status who have adequate access to the health care system.

There are several factors which seem to limit the adequacy of health care among these low-SES Hispanics: (a) problems of access related to poverty, which includes financial as well as knowledge barriers; (b) cultural and language differences which may affect the quality of patient-provider interaction and may also have an inhibiting effect on health care utilization; and (c) the use of "folk" medicine as an alternative coping strategy when access, cultural, attitudinal, language or knowledge barriers to modern health care arise.

In this paper, I will present an overview of problems in research methodology, the literature on health status, and barriers to Hispanic health care utilization. Some suggestions are offered for improving health care delivery and health education efforts. Data and observations based on the 10-year experience acquired by Baylor's Department of Community Medicine in the delivery of primary care in three low-income Mexican-American neighborhoods (barrios) of Houston, Texas, are mentioned. Approximately 20,000 persons receive primary care in three community health centers of the Harris County Hospital District where members of our faculty provide comprehensive care services. The Department of Community Medicine has conducted several health services research projects in these centers.

METHODOLOGICAL PROBLEMS

The two main methodological problems in assessing the published results of health services research among Hispanics are related to imprecise sample definitions and to experimental designs which are inadequate to differentiate the socioeconomic from the cultural factors.

A review of the research on health care problems of Hispanics in the U.S. reveals a lack of uniformity in criteria for selection of sample populations (Aday, Chiu, and Andersen, 1980). There are many variables which account for the broad diversity of subpopulations under the Hispanic rubric. Most obvious is the classification by origin from Mexico, Puerto Rico, Latin America, Cuba, or Spain. Because of a lack of research data on non-Mexican groups, analysis of health care problems for Hispanics must be based for the most part on data from Mexican-American samples. Yet, even within these samples, there is a wide diversity which many studies have failed to take into account. Geographically, Mexican Americans in California may differ from those in Texas, especially among the generations more removed from Mexico. In addition to generational differences, each Mexican American has a language heritage that may reflect monolingualism or bilingualism in the individual, parents, and/or friends. This factor may influence the degree to which Spanish and English communications affect attitude development through social interaction and media.

There is much controversy about how to operationalize selection criteria for Hispanic groups (Aday et al., 1980; Hayes-Bautista, 1980; Hernandez, Estrada, and Alvirez, 1973). There are problems with criteria which rely on Spanish surname, birthplace of parents or self, use of Spanish, or combinations of these (Hayes-Bautista, 1980). In the research literature only about 50 percent of the published studies document how the Hispanic population was defined; many which did used definitions based on surname only, self-designation, or observation (Raschke, 1981).

Much of the survey data thus suffers from imprecise population definition. In addition, surveys can only show correlation, not causation. For example, belief in or knowledge of folk medicine may be correlated with lower health care utilization, but one cannot assume that use of folk medicine indicates a belief system which inhibits health care utilization. The correlation should be accounted for by lower SES, which is a barrier. Folk medicine use may become a second-choice option rather than a substitute for modern care.

To a large extent, the health care problems of Hispanic communities are due to low SES. If the study of these problems is to focus on variables unique to Hispanics, data must be taken relative to non-Hispanic health care problems among groups of similar SES and urbanization. Much research has been done by sociologists and anthropologists interested only in describing features of

Hispanic culture without regard for assessing the degree of problems relative to other segments of society. Fifty percent of the published studies on Hispanics provide data on Hispanics only, making any conclusions about Hispanics which go beyond SES considerations problematic (Raschke, 1981).

Future health services research studies need to: (a) observe closely groups of people who are obviously in the lower SES and in equally urban environments; (b) identify Hispanics in these strata through selection criteria which include, as a minimum, self-identification and behaviors and beliefs which are unique to the particular Hispanic group under study; (c) identify non-Hispanics by the same critieria; (d) compare health knowledge, utilization rates, and morbidity/mortality rates between Hispanic and non-Hispanic groups.

At the present time, the inadequacies of methodology, the disparate populations studied, and the large gaps in critical research areas make general conclusions impossible. Only in a few specific conditions researched can a clear need for special intervention for Hispanics be seen. For example, the reduction of language barriers seems to be an obvious need.

HEALTH PROBLEMS OF HISPANICS

It is clear that, compared to the general population, Hispanics in general have a higher morbidity and mortality rate for some health problems. What is not clear is whether this is due to lower SES or unique features of the specific Hispanic population. Such features might include dfferences in lifestyle, diet, genetic background, or utilization rates. Utilization rates may be lower because of attitudes, language barrier, physical access, or other factors not necessarily related to poverty.

Evidence indicating that the health of Hispanics is generally poorer than the health of the rest of the Nation is listed in Table I. While not an exhaustive listing, it is representative of the overall data available. An obvious problem is that most studies failed to use an appropriate comparison group. Another problem is that statistics were generated from relatively small and noncomparable geographic areas. For example, Mexican Americans in suburban Alameda, California (Stern, Haskell, Wood, Osann, King, and Farquhar, 1975), may enjoy a better climate and health/educational sytem than residents of the Rio Grande Valley in Texas (Trotter, 1981).

Because of the lack of equivalent non-Hispanic comparison groups, compounded by the methodological inconsistencies previously mentioned, few conclusions can be drawn. Hispanic females appear to have a highr prevalence of gallbladder problems, possibly due to an excess of diabetes and Native American genetic inheritance (Diehl, Stern, Ostrower, and Friedman, 1980). Cardiovascular disease may actually be less of a problem for Hispanics than for Anglos, due to less smoking (Friis, Nanjandappa, Prendergast, and Welsh, 1981). However, the national reduction in cardiovascular mortality over the last decade has not been seen in Mexican Americans in Texas (Kautz, Bradshaw, and Fonner, 1981). This may be due to a lack of knowledge about how to reduce cardiovascular risk (Weaver, Herick, Ramirez, and Deatrick, 1978).

TABLE I: Reported Health Problems of Hispanics

Problem	Magnitude	Study Location	Reference
Overall mortality	Higher	U.S. California	U.S. Census Bureau, 1975 Friis et al., 1981
Morbidity/mortality	2-3 times higher	Los Angeles	Gilbert & O'Rourke, 1968
Cardiovascular mortality	Lower Less decline than national trend	California Texas	Friis et al., 1981 Kautz et al., 1981
HBP mortality	Higher	U.S.	Moriyama et al., 1971
Perinatal mortality	10% higher	California	Gilbert & O'Rourke, 1968
Lung Cancer mortality	Lower	New Mexico	Samet et al., 1980
High Blood Pressure	Higher prevalence Lower control in men	Rio Grande, Texas	Stern et al., 1981(a)
Diabetes	Higher prevalence	Rio Grande, Texas	Stern, et al., 1981(b)
Cancer of gallbladder, stomach, and cervix	Higher prevalence	New Mexico	Black & Key, 1980
Gallbladder disease	3 times higher in females	San Antonio, Texas	Diehl et al., 1980
COPD in males	Lower prevalence	New Mexico	Samet et al., 1980
Respiratory disease	Lower incidence	New Mexico	Samet et al., 1982
Infectious diseases	Higher Incidence	Rio Grande, Texas	Trotter, 1981
TB	Incidence 2 times higher	Los Angeles	L.A. City Health Dept.,1966
Intestinal parasites	50% prevalence	California immigrants	Arfaa, 1981
Untreated dental problems	Higher prevalence	Various areas	DiAngelis et al., 1980
Inactivity due to chronic conditions	Same as Anglos	U.S.	National Center for Health Statistics, 1978
Days of bed disability per year	Higher in low-SES Hispanics than Anglos	U.S.	National Center for Health Statistics, 1978

Overall the conclusion can be drawn that virtually all Hispanic morbidity/mortality differentials are due to SES differentials (Roberts & Askew, 1972; Roberts & Lee, 1980). U.S. Government data show that in terms of inactivity due to chronic conditions, and days of restricted activity, health status of Hispanics is comparable to the Anglo population. However, at the lowest SES, Hispanics do show a higher number of days of bed disability per year than Anglos of the same SES (National Center for Health Statistics, 1978).

Poor Hispanics have essentially the same risk factor profile as other persons of the same SES, with the possibility that lack of health knowledge may be causing a relative increase in cardiovascular risk as mentioned above (Weaver et al., 1978). The major risk factors are listed in Table II. Hyperlipidemia may be a true cultural difference due to the greater use of saturated fats in food preparation among Hispanics (Stern et al., 1975).

TABLE II: Risk Factors

Problem	Magnitude	Study Location	Reference
Hypertriglyceridemia Hypercholesterolemia Hyperglycemia	Higher prevalence in males	California	Stern et al., 1975
Obesity	Higher prevalence	Rio Grande, Texas U.S.	Stern et al., 1981(b) National Center for Health Statistics, 1978
Use of saturated fats in diet	Greater	California	Stern et al., 1975
Poor Nutrition in children	Higher prevalence	Rio Grande, Texas	Larson et al., 1974
Leisure-time exercise	Less	Los Angeles	Friis et al., 1981

Risk factors that are related to socioeconomic conditions under which most low-income urban Hispanics live include inadequate sanitation, inappropriate nutritional habits, physical stresses during work, and mental stresses.

The problems that we have encountered most commonly among children of low-income Hispanic families are as follows:

1. Prematurity and infant respiratory distress
2. Low immunization levels
3. Gastrointestinal infections
4. Parasitosis
5. Impetigo
6. Child abuse

Prematurity and infant respiratory distress occur in greater frequency than in high-income populations because the low-income pregnant mothers are at greater risk of having premature infants. These infants in turn are more prone to develop infant respiratory distress. The incidence of prematurity among Hispanics, while greater than among whites, is not as high as among poor Blacks of Harris County.

A major problem in our "barrios" is the low immunization level of children, especially those of preschool age. To some extent, this problem results from inadequate accessibility to preventive health services, but it is mainly due to lack of awareness about these services or to insufficiently-perceived threat.

Gastrointestinal infections, parasitosis, and impetigo constitute other common problems which occur quite often among disadvantaged Hispanic children, especially those who have come recently from Mexico.

Child abuse has emerged in the last few years as a significant community health problem. While it is not limited to Hispanic populations, it must be mentioned as a target for community health-oriented programs.

The health problems that are more prevalent among low-income adult Hispanics follow:

1. Complications of pregnancy
2. Hypertension
3. Ischemic heart disease
4. Diabetes
5. Obesity
6. Venereal diseases
7. Alcohol and drug addiction
8. Mental health problems due to psychosocial conflicts
9. Poor nutritional habits (too much fat and sodium in diet)

Complications of pregnancy account for a high percentage of visits to a primary care facility. The problems of greater concern to us are those of chronic illnesses, such as hypertension, ischemic heart disease, diabetes, and obesity, which constitute the greatest challenge to community health professionals.

Venereal diseases and alcohol and drug addiction deserve special attention although they are certainly not unique to Hispanics. They are the consequences of conditions of poverty, which are not related to ethnic influences. A unique problem may be addiction to chemicals delivered in aerosol spray cans. We have observed several cases among low-SES Mexican-American youths.

Mental health problems due to psychosocial stresses do occur quite frequently among the poor and urban Hispanics. Indeed, these individuals are subjected to considerable pressures brought about by the need to cope with the demands of a milieu which is hostile because of economic, ethnic, and language factors. Given the controversies surrounding the research methodology in this area (Schreiber & Homiak, 1981), it is unclear whether Hispanics suffer more mental disorder than the majority population.

BARRIERS TO UTILIZATION

Table III shows the findings of major research indicating utilization problems. In general, the data show that lower-SES Hispanics tend to underutilize or delay medical care and to use emergency rooms more frequently. There are many diseases for which underutilization appears to be a serious problem.

TABLE III: Utilization Problems

Problem	Magnitude	Area	Reference
Chronic cough, aching joints headaches, stomach pain	Low utilization	Galveston	Chesney et al., 1980
Backaches, fainting spells, fatigue, excessive vaginal bleeding	Low utilization	U.S.	Quesada, 1976
Coughing, sweating, and diarrhea	Low utilization		Zola, 1966
Hospital Immunizations	Low utilization	Los Angeles	Aranda, 1971
M.D. visits Hospital stays	Low utilization	U.S.	National Center for Health Statistics, 1978
M.D. visits Dental exams Eye exams General exams	Low utilization	California	Roberts & Lee, 1980
Health Care Services Emergency rooms	Low utilization Overuse	Ohio	Gliebe & Malley, 1979 Luckraft, 1976
Preventive prenatal and neonatal care	Low utilization	Los Angeles	Bullough, 1972
Free medical exams	Low utilization	Brooklyn	Elinson et al., 1976
Use of home remedy	Overuse	Rio Grande, TX	Trotter, 1981

Although it is clear that the general health of Hispanics is poorer than the health of the Nation as a whole, and that there is a tendency to underutilize or misutilize health care services, there are very few longitudinal data demonstrating the deleterious effects of suboptimal utilization. However, one can assume that if low-SES Hispanics used health care services in the same way as the higher SES, their prevalence of health problems would not be elevated.

There are several reasons why utilization is suboptimal. First and probably most important, there is limited access to medical care due to cost, location, and manpower shortages. Second, language, cultural, and attitudinal barriers may prevent optimal patient-health care system interaction. Third, the Hispanic community has its own health care system which is available as a substitute or alternative when modern medical care is unavailable or undesirable.

Access Problems

Access to health care is generally lower for Hispanics in terms of ability to finance services (Andersen, Lewis, Giachello, Aday, and Chiu, 1981). Private health insurance and Medicare are available to Hispanic persons under the same conditions that they are available to other Americans, and the policies and restrictions are uniform throughout the United States. Medicaid, however, is available under conditions that vary considerably from State to State. In many Southern States the number of persons who are eligible for Medicaid services is far below that of poor people. In addition, a significant number of otherwise eligible persons might not be aware of their eligiblity or have not taken the necessary steps to apply for the benefits because of lack of familiarity with the bureaucracy and the frustrations or red tape involved in submitting an application.

A high proportion of low-income urban Hispanics must rely on publicly-funded health care systems to meet their health needs. Although these public health care systems are more accessible to the urban poor than to their rural counterparts, they still have major inadequacies. From the point of view of the structure of the system, the inadequacies result from: (a) political influence on public health care policy, (b) complex bureaucracy, (c) budget restrictions, (d) shortage of and maldistribution of health care personnel, (e) inadequate incentives for health providers, and (f) the mobile nature of the population.

Political influences are overwhelming in the formulation of public health care policy. Hispanic pressure groups have not been as effective as representatives of Blacks in articulating their views about health care.

The responsibility for the delivery of personal health services falls on different jurisdictions: health department, public hospital, and mental health authority. Usually, the services rendered by these jurisdictions are not well coordinated, and there are no mechanisms to track the services rendered to a given individual by one institution or another.

Perennial budgetary restrictions prevent the providers from organizing the types of services that are needed at a level comparable to that of the private sector. There is also a documented shortage and maldistribution of health care personnel in areas populated predominantly by Hispanics (Bruhn, 1974). Health professionals working in public institutions are not well paid and, in general, lack adequate incentive to provide services with the same level of competence and efficiency as provided in the private sector.

One particular aspect of the structure of the system is the mobile nature of the patient population. The problem has been compounded in the last few years by the large influx of undocumented aliens entering the United States from Mexico in pursuit of better-paying jobs. These aliens at times go to public facilities to receive health care. But the need to register officially in that facility and to show proof of legal residence constitutes a major deterent to the utilization of a health facility until a major emergency occurs.

In regard to the process, the public health care system available to most low-income Hispanics suffers from the following: (a) demand in excess of capacity, (b) superficial contact with numerous health professsionals; (c) inadequate patient-physician relationship; (d) redundancy of services; (e) insufficient coordination, and (f) general inefficiency.

Public health care facilities are burdened with a demand in excess of their capacity; the system is overcrowded. Under these conditions, the low-income Hispanic usually has to establish a superficial relationship with numerous health professionals. There is often an inadequate patient-physician interaction, compounded at times by the existence of a language barrier. This interferes with patient-provider communications and in turn affects the patient's compliance and appointment-keeping behavior. The lack of coordination of services rendered by various public agencies results in redundancy and in general inefficiency.

As to the outcome, the services rendered to low-income Hispanics fall short of reaching the objectives established by health care planners. Since there are major redundancies and inefficiencies in the health care system, the benefit-cost ratio is disappointingly low.

Cultural Barriers to Adequate Health Care

Despite the lack of evidence that Hispanic cultural factors create barriers to health care utilization which go beyond the effect of low SES, many factors are postulated as causal in preventing or inhibiting optimal health care utilization. These factors involve culturally-based attitudes toward health and disease, attitudes toward the health care system, and ways clinics deal with Hispanic patients.

Research may show that utilization rates are not affected by cultural factors. However, it is probable that both belief in the efficacy of treatment and the psychological stress of receiving modern medical care are affected by cultural factors. Such beliefs and stress may have a deleterious effect on treatment compliance and outcome. Thus, the results of medical treatment may be poorer for Hispanics even if utiliztion rates are satisfactory.

Hispanic attitudes and beliefs regarding the causes of disease, why an individual becomes ill, and what should be done may determine health outcome. Poor Hispanic children develop attitudes and values regarding health even before they enter into the Anglo-controlled educational system (Bruhn, 1974). They observe their parents' struggle to survive in an environment of scarcity and deprivation. The children develop a concept of disease as being intrinsic to life. They see disease as caused by the adverse effects of environmental conditions which cannot be avoided. This could develop into a sense of fatalism characteristic of the poor, which limits their preventive health perspective.

Many Hispanics with low formal educational levels believe that illnesses are due not only to chance and circumstances, but also to a divine desire to test the individual's capacity to endure suffering or to punish him or her for some transgression against divine or human law. Some believe that illness involves possession by evil spirits (Galli, 1975).

Among Mexican Americans, an individual may view life as relatively meaningless, merely one in a sequence of generations aiming for an ultimate goal (Quesada, 1976). Because of this, the importance of long-term preventive care becomes less important than immediate symptom relief. This may compound the general problem of lack of motivation to work for long-term goals found in the lower SES.

All of these beliefs may either reduce the perceived need for, or usefulness of, modern medical care. They may also provide support for a decision not to seek medical care when financial barriers exist.

Superimposed on such beliefs may be a large degree of ignorance about disease prevention and treatment. Lack of knowledge of the early signs of illness leads to crisis care rather than early treatment. Lack of awareness of risk factors precludes prevention.

Earlier speculations (Weaver, 1973) were that younger generations of Hispanics would adopt a more scientific view of health and disease. However, Farge (1980) found that younger Mexican Americans were not more scientific in their health orientation than prior generations. He did find that 40 percent believed that good health is a matter of luck, indicating a sizeable degree of fatalism in the community. People who have poor health may tend to blame health status on luck in order to avoid accusations of lack of self-responsibility.

There is some controversy about how low-SES Hispanics view modern medicine. In all likelihood there is a wide range of opinion from total rejection to total acceptance. Earlier studies and speculations indicated that resistance to Anglicization prevented acceptance of modern medicine (Weaver et al., 1973). Poor Hispanics were seen as viewing modern medical facilities as part of the "outside world" (Knoll, 1971). Thus, going for medical treatment is perceived as involving not only strange procedures but also entering into a foreign cultural and linguistic environment.

When visiting a clinic, the Hispanic may be subjected to conditions which would be socially unacceptable in the Hispanic culture (Clark, 1970). Examples of such conditions include gynecological exams by a male physician, or exams requiring total nudity. An Anglo physician may offend a husband's machismo by failing to recognize his role as family leader and decisionmaker, or by giving him a sigmoidoscopic exam without adequate psychological preparation or explanation.

A serious communications gap can occur between Hispanic patient and physician. Doctors are expected to be authoritative, and the physician's asking questions or referring the patient to a specialist may be seen as showing signs of weakness not proper for an authority figure (Quesada, 1976). Thus, an Anglo physician may fail to live up to the patient's expectations while appearing to violate cultural norms and to be insensitive to the paitient's views and beliefs regarding health and disease.

Personnel in health care facilities usually fail to be as personable as would be expected in a Hispanic context. In addition to this, the patient may experience intentional or unintentional racial discrimination. Such insensitivity to cultural factors is often compounded by a lack of understanding or outright ridicule of traditional folk medicine and home remedies. Under such conditions, many poor Hispanics, who justifiably feel they belong to an oppressed minority, may find modern medical care to be dehumanizing or humiliating.

Despite these apparent inhibiting factors, most poor Hispanics seem to accept the fact that modern medical care is the most effective treatment for most diseases. For example, they appear to realize that infectious diseases are best treated by physicians (Trotter, 1981). The fact that in some areas as many as 60 percent of Mexican Americans in the lowest socioeconomic stratum purchase health insurance indicates a faith in modern medicine (Gliebe & Malley, 1979).

While these cultural- and attitudinal-influenced behaviors probably have some effect on utilization quality and frequency, research has failed to show that resistance to Anglicization (Farge, 1980), identification with Hispanic ethnicity or closeness to cultural heritage (Farge, 1980; Welch, Comer, and Steinman, 1973), or attitudes toward modern medicine (Welch et al., 1973) interfere with utilization. Farge (1980) has speculated that the population identified as Hispanic is too heterogeneous in terms of utilization factors for a predictive model to be useful.

Language as a Barrier to Utilization

Basic to the cultural milieu of any setting is language. The lack of Spanish-speaking personnel in medical facilities may be a barrier to utilization, although research data are lacking to demonstrate this. It is known that 76 percent of Hispanics in the United States are bilingual, that 64 percent of Hispanics under 20 prefer Spanish, and that over 65 percent live in households where Spanish is usually spoken (Guernica and Kasperuk, 1982). Chesney, Thompson, Guevara, Vela, and Schottstaedt (1980) found that 60 percent of Mexican-American patients coming to a family practice clinic wanted to be interviewed in Spanish. All this indicates that bilingual/bicultural personnel would be helpful in medical facilities serving the Hispanic community.

In addition to the need to transmit information via a common language, there needs to be a sensitivity to the fact that the quality of the physician-patient interaction may be dependent upon the language used. Scherwitz (1980) found that when physicians used Spanish, they communicated more authority and justification for their recommendations, reflecting perhaps the Hispanic cultural norm for physicians. At the same time, they gave more detailed instruction and more extensive followup-monitoring, perhaps reflecting a feeling that patients who speak Spanish rather than English may be less able to understand and follow directions.

Hispanic Indigenous Health System

Earlier theories (Weaver, 1973) held that poor Hispanics generally subscribed to folk-medicine beliefs and practices. More recent research shows that folk beliefs and practices are less widespread than originally thought and do not appear to represent a significant barrier to modern health care. Farge (1980) reported in his sample of Mexican Americans that 35 percent believed in folk-medicine diseases and cures. While Chesney et al. (1980) found that folk illnesses were treated with folk remedies 80 percent of the time, they also reported that for all illnesses modern medical treatment was sought 83 percent of the time. Among all illnesses treated at home, only 2.5 percent have been found to be folk ailments (Trotter, 1981).

Use of folk medicine seems to be more related to poverty than to ignorance of, or skepticism toward, modern medicine (Farge, 1978). Thus, use of folk medicine today may largely represent a second choice in the face of economic rather than cultural/educational barriers. On the other hand, use of modern medicines or alternatives may depend upon the type of malady.

Some ailments are viewed as treatable in the home, and others as treatable by the medical establishment. Ailments treated in the home are classified as (a) ailments having no medical treatment (*susto*, *mal de ojo*, etc.); (b) those not normally requiring medical treatment (stomachaches, diarrhea); and (c) those for which the patient perceives the medical system has failed to develop a cure (cancer, diabetes, arthritis). These perceptions lead to home care or folk medicine as options which at least offer some hope (Trotter, 1981).

Providers of the Hispanic folk health system include some priests of the Catholic Church, members of the fundamentalist Protestant Church, pharmacists, herbalists, *madrinas*, *curanderos*, *brujos*, and chiropractors (Cervantes, 1972; Clark, 1970). Often health practices involving this system will parallel simultaneous medical treatment. The spiritual needs of the patient and family are met by the churches. *Curanderos* and *espirtualistas* may be used to treat possession by evil spirits (Galli, 1975). The psychological support needed in time of illness may be provided by *curanderos*, who are perceived as more altruistic than physicians. They work within the belief system of their clients regarding perception of illness and treatment efficacy, and they relate socially to the client and his family (Quesada & Heller, 1977). They also make house calls. Chiropractors in the Hispanic community also emphasize a personal relationship with patients, which is supportive and more in compliance with cultural expectations than the behavior of most physicians. Use of pharamcies is usually more accessible and less costly than more appropriate medical intervention. Lower educational levels mean less ability to discriminate between the facts and the propaganda provided by media advertisements regarding health. Thus, poor Hispanics tend to make more use of over-the-counter drugs to combat a whole variety of illnesses (Quesada, 1976).

Although the diagnoses and treatments that are part of Hispanic folk medicine may not be as scientifically appropriate as those of modern medicine, the folk concepts and treatments are intertwined with the Hispanic culture, and thus satisfy the spiritual and social needs associated with illness to a greater degree than does modern medicine. This may explain parallel usage of both traditional and modern systems.

Summary of Utilization Barriers

The socioeconomic barriers to health care are obvious for poor Hispanics. The quality of health care received in the public health care system is usually below that found in the private sector. Language and cultural differences no doubt have a deleterious effect, especially in the psychological and spiritual aspects of health. In the few studies which controlled for socioeconomic and language barriers, health care utilization rate did not differ from Anglos (Gilman & Bruhn, 1981; Welch et al., 1973). However, one can suspect that the results of such utilization may be poorer for Hispanics because of the lower quality of patient-system interaction due to the barriers mentioned.

RECOMMENDATIONS FOR HEALTH PROFESSIONALS

There is a paucity of careful evaluation research which demonstrates what specific changes can be made by health care professionals to improve the level of health care among poor Hispanics. However, there is a wealth of measures which should be tried on an experimental basis, since anecdotal reports and common sense seem to support their use. These involve improving physical and financial access, being sensitive to cultural differences, reducing language barriers, and improving health education efforts.

Improving Access

Obviously, financial access to medical care is limited among poor Hispanics. An analysis of the politics of third-party funding is beyond the scope of this presentation. However, the use of sliding-fee scales might improve utilization. Many clinics now have personnel who help patients get insurance coverage, financial help or loans, or even jobs. Provision of such services could go a long way to improve access and utilization.

Since many poor Hispanics have hourly jobs, it would be beneficial to keep medical facilities open evenings and on weekends. Our experience in Houston shows that utilization justifies having clinic hours on some weekday evenings but not on weekends.

Because the poor may lack adequate transportation, clinics should be located in the immediate community. Mobile vans as portable treatment units have been used to increase access (Aranda, 1971). However, there can be a considerable expense in maintaining and calibrating equipment under the more extreme environmental conditions experienced by portable clinics. Also, the community may view a mobile van as more intrusive and less integrated into the community than a permanent facility.

Improving Physician-Patient Interaction

Identifying a patient as "Hispanic" should never trigger an automatic treatment protocol designed for "Hispanics." To avoid the danger of providing treatment based on stereotypes, it is important to recognize that for any particular patient there will be a unique set of belief, practice, family and community factors. Because of the diversity of the populations and of the beliefs and practices within the Hispanic population, it is incumbent upon health providers and educators to determine empirically for each individual patient what factors exist and how to deal with them.

For example, when dealing with patients, it has been suggested that physicians not ask a patient to make a decisions until he/she can consult with the family, since Hispanic families are close-knit groups (Clark, 1970). According to this view, mothers may need permission from their husbands before electing to undergo medical treatment for themselves or their children. Chesney et al., (1980) have pointed out that the family-practice approach is well suited to such close-knit families. Family and relatives should become involved in treatment, and should be allowed to accompany patients in the clinic and in hospitals to help the patient cope with feelings of alienation in a medical setting. However, Miller (1975) has found a great deal of heterogeneity among family types in Mexican Americans. Therefore the importance of the family must be determined on an individual basis.

The same holds true in terms of the Hispanic's adherence to culturally-prescribed roles. Generally the older and less Anglicized generations will be more sensitive to violations of *macho* or *dignidad* (Quesada, 1976). To preserve masculine attitudes, clinics should take care not to ask males to undress in front of female physicians or nurses. There should be a special sensitivity to the undignified or emasculating perception that some Hispanics have toward such procedures as sigmoidoscopy or pubic shaving. Careful explanation of such procedures, especially by a member of the same ethnic group, may be helpful in desensitizing the male patient so that the procedures are not experienced as damaging to the masculine image. Details on how to examine Hispanic patients with minimal embarrassment have been described (Clark, 1970; University of Texas Health Science Center, 1977).

Clinic procedures should reflect an acknowledgment of folk diseases, without necessarily accepting folk cures, so that patients who subscribe to such beliefs will be assured that the clinic understands their problems from their point of view. Physicians should recognize that choice of folk or conventional medicine depends upon the symptoms. They should learn about folk illnesses and treatment and determine in each case the patient's views on and use of folk medicine, without indicating any negative attitudes toward it. Often a treatment protocol can be arranged which satisfies folk medicine without jeopardizing modern treatment.

On an experimental basis, it might be worthwhile to assess the role of practitioners of folk medicine or faith healers as paraprofessionals working in a scientific primary care center after suitable training. This would provide a bridge between modern medicine and ethnic practices for those patients indicating use or belief in such practices (Quesada, 1976). Delgado (1979) recommends that health-care professionals learn to understand Puerto Rican herbal medicine by visiting the *botanicas* and by involving herbal healers.

The Department of Family Medicine at the University of California at Irvine has initiated an innovative program to train family practitioners to work effectively with poor Hispanic patients (Mull, 1981). This program involves a 3-year residency with a predominantly Mexican-American patient load. Residents are trained in folk medicine. They work with the patients' conceptions of their health problems and integrate modern medicine into folk approaches.

The belief that illness involves possession by evil spirits may lead to use of a *curandero* or spiritual medium (Galli, 1975). There is a need to reconcile spiritual beliefs about illness causation among the patients, the spiritual healers, the Catholic church, and the health professionals. Use of priests in medical settings might be one way to handle illness in a comprehensive manner. The modern holistic health care movement in the middle class has recognized the need to treat the spiritual and psychological components of illness as well as the physical. Indeed, in the non-Hispanic, non-poor, it is estimated that over 60 percent of all patients who come for "medical" treatment have problems which are caused primarily by psychological stress. Thus, modern health professionals should not be too patronizing when dealing with Hispanic spiritualism, which can be interpreted as a valid way of dealing with the spiritual and psychological aspects of health in that culture.

Poor Hispanics, like others in the lower socioeconomic strata, generally have a more difficult time complying with preventive or long-term treatment recommendations. The health-care professional needs to make an extra effort to demonstrate the need and efficacy of self-care and self-responsibility for health care. Case examples of similar patients might be helpful to get across such concepts.

In summary, the physician needs to be personable, sensitive to family and cultural needs, and aware of traditional healing and perceived spiritual involvement. These suggestions apply equally well to physicians serving the majority population, although perhaps to a lesser degree.

Reducing Language/Communication Barriers

The need is obvious to have all verbal and written communications bilingual. Bilingual personnel are also essential. For over 10 years, Baylor's Department of Community Medicine has offered for elective credit two courses in Medical Spanish which are well subscribed by medical students. About 65 students take one or both of these classes each year. The University of California (Irvine) now requires family-practice medical students to take a course in Spanish.

All assessment instruments should be translated into Spanish using local idioms and including local health perceptions and beliefs. Gilson et al. (1980) have outlined the procedure they used to translate the Sickness Impact Profile. But, when giving written materials, care must be taken to determine the literacy of each patient. There is a strong likelihood that a patient who cannot read English also cannot read Spanish. Thus prescriptions and instructions may need to be given to literate family members. The use of pictorial representations of self-care procedures may be useful.

Techniques for reducing communications barriers have been suggested (University of Texas Health Science Center, 1977). These include recognition that the poor may have a tendency to express positive attitudes about modern health care which may not reflect their true attitudes.

To reduce further any language barrier, physician-patient communications should be dialogues for diagnosis rather than one-sided imperatives, because the patient and physician may not use the same words for the same meanings of disease processes even within the same language (Kay, 1979).

Program Development

In developing health care programs for poor Hispanics, special care should be taken to obtain the information needed to ensure a good match between program offerings and community needs. Martinez (1980) cautions that (a) standard survey research must not be used as the only guideline for development, (b) community input and participation is necessary, (c) program information and needs assessment must be disseminated to the community and feedback obtained.

Evidence for the need to obtain community input has been provided by Alcalay (1981). She compared the perinatal health-care needs of Hispanic women as perceived by health-care experts and the providers and receivers within the community. The health-care experts identified the need for improved technical aspects of perinatal health care. The providers and receivers of the care emphasized humanistic needs and the quality of provider-receiver communication. The providers believed that patients' negative biases toward medical professionals posed a barrier to optimal health-care delivery. The community members to be served identified the structural aspects of clinic operations as the greatest perceived barrier. All of these perceptions need to be taken into account to refinehealth-care strategies. An example of an effort to develop more effective programs using community input is reported by Perin (1980). Hospital and community personnel collaborated to put on a symposium to develop strategies to reduce attitude and language barriers. The result was a community-based clinical site operated in cooperation with a Hispanic services center and a medical school.

We have adhered to these principles in the establishment of a network of community health centers of the Harris County Hospital District in Houston, Texas. Each of these centers has an advisory community health council which participates in deliberations related to the utilization of the health center, planning of new facilities and programs, preparation of budgets, etc. Although there is a limited interest on the part of health center users to be elected to the health councils, those who choose to serve provide much useful input to physicians and administrators of the centers. They help to organize political support for obtaining certificates of need or for appropriate allocation of budget resources on a community-wide basis.

Health Educators/Communicators

In terms of health-message content, there are several subject areas that need to be communicated to low-income Hispanics, assuming that knowledge deficits or attitudinal problems are partly responsible for suboptimal utilization. There is a need to demonstrate the value of preventive action and care. Poor Hispanics seem to be less aware of cardiovascular risk factors (Weaver et al., 1978; Ailinger, 1981). The lower utilization rates for conditions listed in Table III, such as chronic cough or excessive vaginal bleeding, also need to be targeted in health communications.

Health communications need to counter the belief in nostrums, pointing out that most are for symptom relief only, having only temporary effects, and that failure to get proper care can lead to more serious and expensive treatment.

When health communications are designed to lower utilization barriers, marketing techniques should be considered. In order to minimize the perception that modern medicine is part of the "outside world," messages should be bilingual and bicultural. Clinics and hospitals should hold meetings and free lectures, demonstrations and examinations in collaboration with existing and respected community institutions, such as the churches, in order to gain community acceptance.

Health messages should be in concordance with cultural values regarding the importance of family life, spiritual values, and appropriate sex-role models. Guernica and Kasperuk (1982) have elucidated such aspects of marketing to the Hispanic community.

Schultz and Rogers (1981) have developed a model for the development and evaluation of videotaped messages for Hispanics. They have taken into consideration such factors as realism and Spanish-language comprehension. Videotapes can be presented at locations convenient to community residents, and might be excellent trigger media to stimulate discussion when shown by Hispanic health-care personnel. Falck (1979) has suggested using churches, local industries, neighborhood agencies, and private homes as settings for health education for reaching those not reached through ordinary channels.

Poor people in general are most likely to receive information through audiovisual mass media. Gombeski and Moore (1981) found that Mexican Americans in Texas reported that television was their second most important source of health information after physicians. Hispanics are also likely to listen to Spanish-language radio stations, since these are the only media which provide ethnic music (Guernica and Kasperuk, 1982). Such media exposure patterns need to be taken into account.

One innovative idea to integrate health messages into the existing folk health information system has been an attempt to train merolicos, or medicine showmen, to deliver modern health messages. They could be trained to deliver messages on venereal disease, nutrition, family planning, and other topics (Simoni, Vargas, and Casillas, 1981). By so doing, these merolicos could act as a link between physicians and health-care consumers, using an existing and popular information channel.

The Communications Core of the National Heart and Blood Vessel Research and Demonstration Center, Baylor College of Medicine, has developed several health education programs for the Mexican-American community. As part of its Community Health Information Program, several radio and TV public service announcements (PSA's) were designed to increase awareness of the problem of hypertension and to stimulate remedial action. Message language and culturally-relevant appeals were determined through focus groups conducted in the community. Media and educational professionals from this target group served as content consultants. The PSA's were designed to generate audience response via telephone call-in for more information. Callers received a brochure explaining hypertension detection and treatment. A list of health-care facilities was included. Those exposed to the PSA's wre three times more likely to report visiting a clinic for a blood pressure check than those who were not exposed.

Another project of the Communications Core also recognized the importance of radio as a medium for health education communications. In cooperation with a Spanish-language radio station in a small town, brief "novela" or "soap-opera" dramas were presented, with cardiovascular risk information interwoven into the plots. These messages were coordinated with a "Health Fiesta" held at the major Catholic church. At the Fiesta, health professionals gave free screenings for a variety of health problems and distributed information on the health care facilities available. In addition, Mexican foods prepared with lower fat and salt content were served, along with the recipes.

Areas for Future Research

Important research questions remain unanswered mainly because we do not have adequate data bases on the volume, type, quality, cost, and effectiveness of the health services rendered to Hispanic persons (Vallbona, 1980). The following is a partial list of the questions we have formulated throughout the past 10 years. The list reflects our biases and the needs that we have perceived in attempting to quantify the health-care needs of low-income urban Hispanics and to implement rational community health programs which will meet these needs:

1. What is the level of utilization of health services by Hispanic persons by specific ethnic origin and socioeconomic status?
2. What factors lead to underutilization of health services by young and middle-age low-income Hispanic males?
3. What attitudes may be fostered through health-education programs that will lead to greater utilization of preventive care?
4. What is the influence of religious beliefs in the acceptance of family-planning methods by young Hispanic women?
5. How effective is the communication between provider and consumer in the face of language and sociocultural barriers?
6. What is the level of compliance to prescribed treatment regimens, and what are the obstacles to achieving good compliance?
7. Can visiting-nurse home services be effective in complementing the services rendered in primary-care centers?
8. How can poor appointment-keeping behavior be favorably modified?
9. What is the extent of folk-medicine utilization among Hispanics of various ethnic and socioeconomic groups?
10. Can networks of folk healers be described, and can they be integrated with the scientific health-care system?
11. What motivating factors can be fostered among low-income young Hispanics to enter health careers?
12. What factors have led to better integration of Hispanic physicians in professional organizations than has been the case of Black physicians?
13. Is there a desire to maintain a Hispanic identity on the part of the ever-increasing number of young Hispanic health-care professionals?
14. Will there be any difference in the acceptance of cost-containment policies between Hispanic providers or consumers?
15. Can Hispanic paraprofessional health workers be trained to promote preventive health practices in low-income Hispanic neighborhoods?

We must start making provisions for improved documentation of the ethnic and socioeconomic characteristics of Hispanic users of our health care systems. We must use precise criteria for the specific identification of these users in order to develop the data bases needed to answer the above questions. We must conduct prospective and retrospective studies to impart validity to newly-acquired knowledge and to ensure transferability of experimental community health programs that have proved to be effective in certain environments.

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HISPANIC HEALTH MANPOWER DEVELOPMENT

1. "Obstacles to Hispanic Health Manpower Development"

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2. "Assessing Program Strategies for Recruiting Hispanic Talent"

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"Obstacles to Hispanic Health Manpower Development"

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Hispanic health manpower development issues have been raised only recently by the public and private sectors, largely as a result of growing awareness of this population's health needs and programmatic issues arising from the rapid increase and diversity of the Hispanic population. It was only during the second half of the 1970's that the public sector began to examine the needs of our community and their relationship to health delivery and health manpower development. The area of critical importance, and probably the cornerstone of adequate planning, development and delivery of most health programs, is Hispanic health manpower development. It is amazing that we have taken so long to recognize the dificiency. However, we are here today to examine how we can fill this void.

Hispanics constitute a rapidly-growing segment of this Nation's population. According to the 1970 census, there were 9.6 million persons of Hispanic origin in the United States. The 1975 population reports recorded an increase to 11.2 million. The 1980 census reports a count of 14.6 million persons of Spanish origin (U.S. Census of Population and Housing, 1980). Other estimates, which take into consideration census undercount, increase from births, and legal as well as undocumented immigration, indicate that probably more than 23 million Hispanics live in the United States today. Furthermore, statistics show that they are the fastest growing ethnic group, and it is expected that by the year 2000 the number of Hispanics will be somewhere between 26.5 and 55.3 million. Even by moderate estimates, they will become the largest ethnic minority in the United States within the next 25 years (Macias, 12977).

Socioeconomic Considerations

Hispanics are largely urban dwellers. Approximately 84 percent of them reside in metropolitan areas, particularly in central cities. One out of every two families of Hispanic origin lives in the central city of a metropolitan area, compared with one out of every four families in the general population.

Hispanics are the youngest of all ethnic groups, with a median age of 20.7 years, compared with 28.6 years for the general population (U.S. Census, 1976).

The Spanish language continues to be a most significant aspect of Hispanic cultural heritage. Some studies indicate that more than 80 percent of Hispanics report Spanish as the mother tongue, while 20 percent report difficulty with English (President's Commission on Mental Health, 1978).

Status of Hispanic Health Manpower Development

Many individual cases of successful entry into the health manpower pool by some Hispanics could be cited here. However, our purpose is not to find out about this increment but to analyze the larger picture--the impact that the total health manpower development programs have had on developing Hispanic health manpower.

Statistics are unclear, due to an overlap between population groups, a nondefinition of Hispanic or Spanish-surnamed, and a lack of a centralized data bank on Hispanics.

Some divisions within the National Institute of Mental Health have provided some data. For example, in 1972, 23 Hispanics were enrolled in research training programs, or 1.4 percent of a total of 1,652 persons enrolled; in 1974, 34 Hispanics were enrolled, that is, 2.1 percent out of a total of 1,605. Hispanics are also underrepresented in the major health professions.

TABLE I
Hispanic Representation in the Major Health Professions

Profession	Spanish Surnamed	White
Medicine 1974-75	638 (1.2%)	47,994
Dentistry 1974-75	210 (1.1%)	18,122
Optometry 1971-72	30 (1.0%)	2,887
Pharmacy 1974-75	278 (1.3%)	20,401
Podiatry 1971-72	5 (0.4%)	1,227
Veterinary Medicine 1971-72	23 (0.4%)	5,067
Nursing 1972-73	3,638 (1.9%)	176,138

Source: Minorities and Women in the Health Field, 1977.

When comparing these statistics with the total population, a clear discrepancy is evidenced between Hispanic manpower development training and the total population in the various programs.

The same underrepresentation discrepancy remains in the lower status health professions.

TABLE II
Hispanic Representation in Selected Health Care Occupations

Occupation	Hispanic American	Total Population
Clinical Laboratory Tech.	4,781 (4.0%)	118,264
Dental Assistant	3,150 (3.5%)	90,497
Dental Hygienist	162 (3.5%)	17,457
Dental Laboratory Tech.	1,825 (6.8%	26,810
Dietician	1,149 (2.9%)	40,225
Health Administrator	1,122 (1.3%)	84,461
Lay Midwife	79 (8.4%)	941
Nursing Aide	29,312 (4.1%)	723,576
Practical Nurse	8,795 (3.7%)	235,546
Radiology Technician	1,994 (3.8%	52,566

Source: Health of the Disadvantaged Chart Book No. II, DHHS, 1980.

The only occupations in which Hispanic representation is above their proportion in the general population are dental laboratory technician and lay midwife.

A significant factor in meeting the health care needs of Hispanics is the number of Hispanics who have been trained in the health care professions. A review of trend statistics indicates that Hispanic enrollment in schools of health professions, as inadequate as it is, has remained relatively stable over the past several years, except for enrollment in medical schools where there has been a steady percentage increase.

TABLE III
Hispanic Enrollment in Selected Health Professions Schools by Profession and Year: 1971-72 through 1978-79

Year	Osteopathic Medicine	Dentistry	Veterinary Medicine	Optometry	Pharmacy	Podiatry	Nursing
1971-72	19 (0.8%)	93 (0.5%)	23 (0.4%)	30 (1.0%)	203 (1.2%)	5 (0.4%)	NA
1972-73	18 (0.7%)	132 (0.7%)	20 (0.4)	43 (1.3%)	254 (1.4%)	10 (0.8%)	NA
1973-74	12 (0.4%)	185 (1.0%)	28 (0.5%)	47 (1.3%)	343 (1.7%)	9 (0.6%)	NA
1974-75	12 (0.4%)	225 (1.1%)	35 (0.6%)	NA	278 (1.2%)	14 (0.7%)	3,237
1975-76	23 (0.7%)	263 (1.3%)	NA	55 (1.4%)	359 (1.5%)	18 (0.9%)	3,837 (1.5%)
1976-77	27 (0.7%)	293 (1.4%)	37 (0.6%)	46 (1.1%)	353 (1.5%)	14 (0.6%)	NA
1977-78	NA	330 (0.8%)	NA	55 (1.3%)	360 (1.5%)	21 (0.9%)	NA
1978-79	NA	414 (1.9%)	NA	66 (1.5%)	376 (1.6%)	27 (1.1%)	NA

Source: Health of the Disadvantaged, Chart Book No. II, DHHS, 1980.

While enrollment has not increased significantly in the health professions listed above, there has been a steady increase in the number of Hispanics who are enrolled in colleges of medicine.

TABLE IV
Enrollment in Schools of Medicine in the United States by Ethnic Cateogry: 1968-69 through 1979-80

Academic Year	Hispanic American	White American
1968-69	62 (0.2%)	34,558 (96.4%)
1969-70	118 (0.3%)	36,060 (95.7%)
1970-71	196 (0.5%)	37,944 (94.3%)
1971-72	328 (0.8%)	40,578 (93.0%)
1972-73	451 (1.0%)	43,448 (91.7%)
1973-74	619 (1.2%)	45,911 (90.5%)
1974-75	1,224 (2.3%)	47,580 (88.8%)
1975-76	1,473 (2.6%)	49,457 (88.6%)
1976-77	1,645 (2.8%)	50,978 (88.3%)
1977-78	2,050 (3.4%)	52,779 (87.9%)
1978-79	2,265 (3.6%)	54,617 (87.8%)
1979-80	2,512 (3.9%)	55,672 (87.3%)

Source: Health of the Disadvantaged, Chart Book No. II, DHHS, 1980.

When medical school enrollment figures of Hispanics are compared with those for whites, the increased matriculation by Hispanics practically equals the decreased percentages for whites. In fact, Hispanic enrollment has increased during the past 6 or 7 years, yet Hispanic representation in all of the health care professions is considerably below expectations when compared with representation in the general population.

Health Status of Hispanics

A major problem is the lack of health providers (white and non-white) to handle the many health problems present in Hispanic communities. Rudov & Santangelo (1978) indicate the following: that a non-white is more than three times as likely to die of hypertension as is a white of the same age group, 60 percent more likely to die of cerebrovascular disease, and almost four times as likely to die of hypertensive heart disease; that non-whites are twice as likely to die from diabetes and four times as likely to die of chronic kidney disease; and that non-whites suffer nearly four times the amount of narcotic drug abuse, have a 40 percent greater likelihood of psychiatric hospitalization, and have twice as much speech impairment and 60 percent more severe vision impairment than whites.

Vital statistics provide an objective measure of health status; however, an equally important measure is the status of health as perceived by the individual.

TABLE V
Self-Report of Selected Health Characteristics
According to Ethnicity, 1976-77

Ethnicity	Population in thousands	Health Status Reported Fair or Poor	Limitation of Activity	Some Form of Health Insurance[1]	Restricted Activity Days[2]	Bed Days[3]
		Percent of Population			Number Per Person Per Year	
Total	211,400	12.3	13.9	88.6	18.0	7.0
White	160,129	11.0	14.0	90.8	17.6	6.6
Hispanic	11,913	12.8	9.1	75.7	16.7	7.8

1. Includes private insurance & medicare/medicaid.

2. Includes bed days, work loss days and other restricted-activity days.

3. Bed days are a subgroup of restricted activity days.

Source: Health of the Disadvantaged, Chart Book No. II, DHHS, 1980.

Hispanics perceive themselves as being in fair or poor health more frequently than individuals in the total population yet are less likely to have insurance coverage and more likely to continue to work in spite of their perceived health status.

These and other conditions will continue to mount as long as obstacles to Hispanic health manpower development continue unchallenged.

Bureaucratic Obstacles

Federal, State, and local governments allocating assistance for various programs use parameters on the basis of demonstrated need. The size of the population to be served and its social and economic characteristics are recorded in the census figures. The Bureau of the Census, however, acknowledges the probability that an undercount could affect adversely the allocation of Federal funds to Hispanics in major urban centers. Many federally-assisted programs are designed to aid disadvantaged persons. Federal programs need social and demographic data to identify the needs of disadvantaged communities. In order to devise remedies where deficiencies in health manpower development can be corrected, it is essential for Federal agencies to have, or develop, accurate data on the race and ethnic origin of the intended beneficiaries.

Health Professional Obstacles

The shortage of health professionals qualified to provide services to the Hispanic population has been well documented. To be effective health practitioners serving a Hispanic population, the practitioners must have a thorough understanding of, and a sensitivity to, the linguistic and sociocultural characteristics of this population. These characteristics and styles are foreign to the typical health professional, creating a situation which handicaps the service providers, alienates those most in need of professional help, and often results in ineffective and inefficient utilization of our health manpower pool (President's Commission on Mental Health, 1978).

It is obvious that an increase in Hispanic health manpower development programs is of critical importance. Public policies in this area need to be reexamined, and adjustemnts in the allocation of funds in manpower development require further evaluation.

Hispanics remain severely underrepresented in most, if not all, levels of manpower development. The supply of qualified professionals continues to lag further behind the increasing demand for services.

Obstacles in Priority Setting

Most, if not all, the Health and Human Services departments/divisions develop annual forward plans based on predetermined goals and priorities. These priorities come from an array of sources; most come from research and data sources accumulated and analzyed during the prior year. But where there is little research and a vacuum of information on actual need, only "guestimates" can be made. The situation is aggravated when setting priorities for the Hispanic population is attempted.

Two years ago, an interregional health resources team, of which the senior author was a member, was charged with the responsibility of determining priorities based on needs, and to no one's surprise health manpower development was at the top of the list.

Obstacles of Misinterpretation of Supreme Court Decision

The Supreme Court's far-reaching Bakke decision is likely to become for years to come one of the Nation's favored intellectual exercises. We believe the only winner in this case was Mr. Allan Bakke, who was admitted into medical school. Losers in the short run are the minorities, who were making inroads in health manpower development through legal affirmative action programs, and who in all probability will see years of progress coming to a slow crawl, simply because critics of these programs believe that the Court's middle-of-the-road position merely encourages more reverse discrimination suits.

Other Obstacles to Hispanic Health Manpower Development

Obviously, many obstacles can be cited. Let us mention just a few, such as legislative obstacles, that is, laws that are enacted usually for aggregate racial groups, leaving the ominous task of allocation of few resources to misinformed staff.

The media has been an obstacle at times, by not accurately portraying the plight of Hispanics and their health needs and by developing in isolation their own newsworthy priorities. This is not to say that public TV at times has not done some commendable work.

Conclusions

The solution to removing these obstacles is no easy tak and probably requires an ongoing process of communications and receptivity to the needs of Hispanics.

Public officials have a tremendous responsibility when developing guidelines and plans to implement laws from Capitol Hill to assure that Hispanic needs are fully examined, and that efforts be made to obtain information when it is lacking.

The easy solution would be to provide more funds for health manpower development, but I believe an issue of this magnitude requires an assessment of present priorities and a reallocation of existing resources.

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"Asessing Program Strategies for Recruiting Hispanic Talent"

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There is ample evidence that far too few Hispanic health professionals are currently being trained to meet the health care needs of the Nation. Allow me to simply cite a few examples which will point this out. It is estimated that there are approximately 16 to 20 million Hispanics in the United States, or about 65 percent of the total population. Comprised primarily of Mexican Americans or Chicanos, Puerto Ricans, and Cubans, it is currently the most rapidly increasing minority group in the U.S. Enrollment data from 1981 show that Hispanics made up only 3.0 percent of the total enrollment in medical schools, 2.0 percent in dental schools, 1.5 percent in pharmacy schools, and 6.4 percent in public health schools, the last being the only one where parity is apparent. Of the approximately 800 Mexican-American physicians practicing in the United States, about 70 percent have graduated from medical school since 1972.

Several reasons have been offered for the small number of Hispanics applying, entering, and completing health profession schools. These include: lack of role models, inadequate counseling in high school and college, poor academic preparation, lack of money, lack of family support, certain cultural elements, and language difficulties. Programs which address these problem areas have been instituted in middle, secondary, undergraduate, and health profession schools and have been primarily concerned with identification, motivation, recruitment, admission, and retention of students. Programs with large numbers of Hispanic participants are found in three general areas of the country: the Southwest sector, consisting of Texas, New Mexico, Colorado, Arizona, and California, where the majority of the Mexican-American population is located; the New York-New Jersey area and Florida, which contain a large Puerto Rican and Cuban population. However, one must not overlook the fact that large numbers of Hispanics are also found in most major cities throughout the United States and participate in programs in these areas.

Program strategies have included the use of faculty and students from colleges and health profession schools to provide information regarding admissions and various health career fields; staging of "health fairs," "health career days," and the formation of "health clubs"; career and psychological counseling; academic tutoring; teaching of study skills; financial aid information; tutors of health care and health school facilities; summer laboratory or clinical preceptorships and summer reinforcement projects for upper-level preprofessional undergraduate students.

Involvement of the parents in many of these activities is an essential part of a project's success. The use of faculty and student role models is also extremely effective. Teachers and counselors offer a good resource for identification of potential Hispanic health professional students. However, I must point out a problem which I have personally encountered in working with secondary, undergraduate, and professional school faculty. Often this group must be educated to the concept that it is not only the "superminority" student who already stands out as being a motivated achiever who should be identified. They must also look for those students who have a potential which needs to be nurtured and developed. In this respect, many of us have been appalled at the poor counseling offered to students. This may be due to a lack of information, an overburdening of the counselor with administration and test duties which do not allow for any personal counseling, a preconceived notion regarding what constitutes a successful student, or a general lack of interest.

Particularly succesful programs are those in which an undergraduate institution may be part of a school system which has a variety of health professions schools. A cooperative agreement may be arranged to provide the students with opportunities to visit these schools and meet with faculty and students. Often these health professions schools are also willing to interview the program participants, and many of them are admitted because of this close collaboration between the institutions.

Also successful are summer reinforcement programs at health professions schools which enroll propsective applicants and provide them with enrichment courses in the sciences, English, reading, and study skills, as well as an opportunity to meet and observe students and faculty in the school. Many of the summer courses follow the same format and content as that offered in the first year of a health professional school. These types of summer programs not only provide academic reinforcement for the student, but also allow them to become familiar with the school environment.

Let me briefly identify a few of these programs. The Health Career Opportunity Program (HCOP) sponsored by the Office of Health Resources Opportunity (OHRO), Health Resources Administration, supports programs designed to increase the number of disadvantaged students, particularly minorities, into schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, and pharmacy. Projects funded for this purpose range from the identification and distribution of career information to senior high school and undergraduate students to retention activities for students already enrolled in health professions schools. Many of the programs follow the formats previously described for the summer reinforcement programs.

The Minority Biomedical Research Support Program (MBRS) sponsored by the Division of Research Resources of the National Institutes of Health supports research projects in universities and colleges with a substantial minority enrollment. Although this program is directed primarily towards increasing the number of minorities in biomedical research, it also provides an opportunity for these groups to improve their academic training and research ability, thereby making them more competitive for admission to health professions schools.

The Minority Access to Research Careers (MARC) sponsored by the National Institute of General Medical Sciences of NIH provides funds for advanced scientific training of minority faculty. This improves the scientific capability of the faculty to train students at minority institutions, and enhances the probability of their acceptance into health professions schools. This office also honors a MARC program for gifted minority students in undergraduate schools with predominantly minority enrollments. The program will sponsor enrichment courses and laboratory research, thereby also increasing the students' ability to compete for admission.

The Graduate and Professional Opportunities Program, administered by the Bureau of High and Continuing Education, funds institutional programs developed to increase the number of minorities enrolling and completing a master's or doctoral degree in underrepresented areas. Students who receive advanced degrees in science under this program would also be in a better situation to compete for admission to a health professional school.

The Biomedical Sciences Program (BSP) sponsored by the Office of Education funds activities which strive to motivate minority high school students into biomedical research or health careers. This program is somewhat unique in that it provides funding over a 5-year period for projects which begin with 8th-grade students. Thus a student may be involved in a program from the 8th through the 12th grades. This is one of the few national programs that work with students during their early years in secondary school.

Financial aid for students is provided by the Office of Education through a variety of well-known programs, such as the basic educational opportunity grants, the college work-study program, and others. Various national professional health organizations, such as the American Medical Association, the National Medical Association, and the American Dental Association, also grant scholarship funds for disadvantaged minorities. Funds for projects to increase the number of disadvantaged minorities in health professions, or scholarship aid, are also available from private foundations, such as the Robert Wood Johnson Foundation, the Joshua Macey Foundation, and others.

There have been two recent reports dealing with an assessment of what constitutes a successful program for recruitment and admissions of minority applicants in health professions schools. Both state emphatically that the projects which had strong backing from an institution were more successful. Acceptance and success of a program was also greater if the project director was a faculty member with committee membership on admissions, promotions, academic affairs, etc., and active in State and national professional organizations. Furthermore, such a person was able to exert informal influence and provide a wider exposure of the program to the educational institution than a project director without faculty rank. The formation of institution-wide committees or support of such committees for a project also aided in the acceptance and success of the project. Clearly-voiced support from the dean and financial commitment by the school were also beneficial factors. Both reports concluded that underrepresentation of minorities existed and that stronger recruitment efforts were needed to increase the number of applicants.

At this point I would like to interject two personal observations regarding my own personal experiences in these types of programs. Programs involving high school students or undergraduate students are more successful if they utilize other undergraduate or health professional students as role models. If these students are Hispanics or graduated from the same high school or college, the rapport between the students is enhanced and the objectives of the program are more easily achieved. High school students appear to relate much better to college and professional school students than to faculty. Furhermore, they seem to be more impressed and enthusiastic about the advice given to them by other students regarding health careers.

Anecdotal material provided by Hispanic students as to how they made it through the system and are now in college or pursuing a health career appears to be an excellent stimulus to younger students. However, one problem is the small number of Hispanic student role models available to work in a program. High school students will relate to nonminority students, especially if the program activities require them to spend considerable amounts of time together. One of the interesting aspects of the use of nonminority students is the fact that their involvement sensitizes them to the educational and health care problems of Hispanics. Many of them become avid advocates of minority programs once they have worked in them.

My second observation concerns the once- or twice-a-year "Health Career Days" or similar projects without any effort at an adequate follow-up or contact by the schools or faculty members. Such efforts are not successful recruiting tools. The lack of reinforcement, both at home and at school, does not provide an environment for most Hispanic students to develop their motivation or potential to enter a health career. Unless contact or information is provided throughout the year, the student will lose interest.

What has been the success of these programs in terms of their national impact on increasing the number of Hispanic health professionals? Perhaps the easiest, and also perhaps the most naive, way of measuring this is to evaluate the enrollment, retention, and graduation trend of Hispanics in health professions schools during the past several years.

Most of the programs directed at effecting such an increase have been in existence since 1971. Statistical data for the number of Hispanics applying, admitted and graduated from health professions schools is adequately documented only for medical, dental, pharmacy and public health schools. If we use only the data available for these schools, we find that there has been, until now, an increase in the number of Hispanics admitted and graduated from these schools. However, except for the Hispanic enrollment in schools of public health, this group is still underrepresented in spite of increased enrollment, since it comprises roughly 2-3 percent of the total enrollment in medical, dental or pharmacy schools, while 6 percent of the total population is classified as Hispanic.

A contracted report prepared for the Bureau of Health Manpower states: "The underrepresentation of most bilingual/bicultural minorities in medical schools seems due, at least in part, to the very small size of the applicant pool from these groups." The total number of Mexican-American and Puerto Rican applicants to medical school in 1975-76 very closely approximated the acceptance rates. That is, these groups comprised 2 percent of the total applicant pool and about 2 percent of the final enrollment figure.

Examination also reveals that retention of Hispanic students is also rising probably due to increased academic supportive services available to these students, strong minority programs backed by the administration and faculty, and development of new teaching strategies. The report further states that "....minority recruitment programs must tackle complex, pervasive obstacles, reaching far beyond the province of the health professions schools, the programs will undoubtedly have to continue for many years before any impressive changes in the statistics show up."

National figures show that the applicant pool for all minorities has been decreasing over the past 2 years. The question we may ask is: why and what can be done to reverse this trend? The Bureau of Health Manpower Report states: "If sufficient bilingual/bicultural health professions are to be trained to provide the health care needed by minority groups, a concerted effort must be made to recruit more bilingual/bicultural applicants to health professions schools. Health professions schools, supported and provided by the Federal Government, need to make strong minority recruitment efforts. These efforts should put greater emphasis on bilingual/bicultural minorities, who have received inadequate attention in past minority programs."

One strategy for increasing the pool of Hispanics into health professions schools is early academic preparation and motivation. Many of the Hispanic students are lost because they either drop out of school or receive inadequate counseling and motivation to prepare themselves academically to continue their education into a health career. It is imperative that identification of these students be done as early as possible.

I would suggest that elementary school would not be too early. Middle schools are certainly fertile grounds, but the later years of secondary education are too late for most because of the academic preparation which students should have in order to continue the undergraduate training required for entrance into a health career or a health professions school. Students who face the prospect of having to take remedial or noncredit courses in undergraduate school, due to the fact that they do not have the required courses or receive poor academic preparation or inadequate counseling, are frustrated and often either do not enter college or choose a field which does not require the scientific preparation of a health career.

Data indicate that most Hispanic students who drop out of school do so between the 7th and 10th grades. Thus we are looking at the survivors of the system when we work with pupils who are juniors or seniors in high school, and at the "cream of the crop" for those who are in college. Interestingly, the Health Career Opportunities Program administered by OHRO is one of the principal funding sources of programs directed towards increasing the number of disadvantaged minorities into the health professions. Yet, because of limited funding, it has had to eliminate programs which work with students below their senior year in high school!

Programs of this type should begin in the earlier grades. Our educational system has already recognized the importance of early career training. The Office of Education has encouraged career education in kindergarden. Why then can we not have health career programs which begin at the fourth or fifth grades? Such programs should involve cooperative efforts between school districts, undergraduate schools, and/or health professions schools. It is obvious that these would be long-term projects and therefore not as popular or palatable to many who wish to see more immediate results. I am also well aware of the problems of obtaining legislative approval for such long-term projects.

There are many who feel that it is not a shortage of Hispanic applicants that is maintaining an underrepresentation of this group in the health professions but that the problem lies with admissions criteria used by the schools. This is certainly a legitimate argument. I have served on admissions committees long enough to realize that an applicant's grade point average and aptitude scores are strong factors used to evaluate the acceptability of a student. This continues despite the large number of articles published in scientific journals by nonminority health educators showing that there is no correlation between grade point average or aptitude scores and a student's academic or clinical performance. It has been the experience of our institution that students who are accepted with average or somewhat below aptitude test scores but with a grade point average close to 3.0 have minor academic difficulties.

Admissions criteria certainly should be examined in terms of evaluation of other factors besides academic qualifications for admissions. I believe that strong and successful Hispanic minority admissions programs at health professions schools require the presence of Hispanic faculty at the institution. Hispanics with good academic credentials who hold tenured faculty or administrative posts are in a better position to wield influence on deans and committees. Unfortunately, the number of Hispanics on health profesisons school faculties is extremely small. For example, we have estimated that in the seven medical schools in Texas there are less than a dozen Mexican Americans appointed as full-time faculty. It is hoped that programs such as the Minority Biomedical Support Program and Minority Access to Research Careers Program will produce more Hispanic basic scientists who will take faculty positions at health professions schools.

I believe we must have both long- and short-term goals in order to increase the numbers of Hispanics into health care delivery. However, one should be aware that the recent Bakke decision will make it much easier for schools to continue their already weak or practically nonexistent affirmative action admissions policies. The argument of "we should admit only qualified applicants," with qualified being defined according to the traditional academic concept, will continue to be debated and used.

If Hispanics cannot receive help to eliminate some of the obstacles which arrive early for them in their presecondary education, then we will be faced with the same problems of having to provide remediation for the meager handful of high school graduates who still retain some motivation for a health career. Such a situation will hardly help to increase the applicant pool.

I would like to close with a quote from a paper presented by Casaventes, at the American Association for the Advancement of Science in 1972, which states the basic concept of early preparation: "With the idea of becoming a professional person firmly in mind, the course of a student's life in the precollege period is radically altered, or to put it in another way, the idea to become a professional must usually be internalized by the student long before he or she enters professional school. The course of studies to be chosen, the ancillary reading, the informal interest--in science, or music, or education, or in commerce--begin years before the degree is granted."

HEALTH CARE SERVICES

"Utilization of Health Care Services by Hispanics"

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"Utilization of Health Care Services by Hispanics"

Francisco Velasquez
The South Texas Health Consumer Association

I have a firm belief that health is a "human right" for all Americans--rich or poor. Secretary Joseph A. Califano in a recent address to the World Health Organization addressed this point as he stated:

> ". . . a simple belief, that is also a central tenet of the World Health Organization: that a decent standard of health is a fundamental human right, for the world's poor no less than for the rich. . . . this. . . conviction (should be) woven into the policies of the government . . . a government renewing its commitments to human rights and human well-being."

A general overview of socioeconomic conditions indicates that in all probability health services are underutilized by Hispanics. The development of strategies to promote greater utilization of available health services is necessary, as it is important to develop more comprehensive health systems.

Given the larger number of members per family, of Chicano and Puerto Rican families in particular, and the fact that less than 50 percent of this population group have completed high school, and the correlation of this fact with a higher standard of living, these groups truly fit the definition of "working poor." Not only do we underutilize health services, but we underutilize almost all social and human service programs. The working poor Hispanic is further victimized by the very low level of labor union participation, thereby not having the benefit of union-sponsored health plans, and even further, by not being able to afford adequate private health insurance plans for their families.

Perhaps if we use the socioeconomic conditions among Chicanos in South Texas as an example, we can begin to see how conditions which affect the quality of life can directly influence the utililzation of health care services. In its 1977 report on the health of Mexican Americans in South Texas, the Lyndon B. Johnson School of Public Affairs offered many dramatic examples of the poverty that many Chicanos endure. I will touch on their findings only generally. Population and fertility data suggest that specific programs such as maternal and child care programs will need to have a greater impact on Chicanos. In fact, one comment from the report should be of interest, ". . . the (population) pyramid for Chicanos resembles those of developing countries where there has been a marked decline in infant and child deaths and where fertility has not yet been reduced. In such populations, the number of people is increasing rapidly, median ages are falling, and youth and total dependency ratios are high."

Basically, the report comments on the extreme poverty that exists in South Texas and on the relationship between poverty and health status. The report points out that people with low income become sick more often and that they are less likely to seek medical help. In some counties of South Texas the percentage of Chicano families under poverty is astronomical. Chicanos here are among the poorest in the Nation, and wide disparities exist between ethnic groups. The mean family income of Chicanos is slightly over 50 percent that of Anglos; and in non-SMSA counties it is nearly half that of Anglos. Per capita income differences are even greater: Chicanos have less than 40 percent the income of Anglos overall.

The Lyndon B. Johnson School of Public Affairs report cites other dreadful statistics regarding unemployment, housing, and sanitary facilities and summarizes health and poverty-related problems as follows:

-- The low income of many Chicanos gives them less money for medical services. Lack of funds may require the foregoing of medical services or reliance on assistance from others (e.g., family, friends, charities, or public funds).

-- The lack of formal education among many Chicanos suggests that they are less likely to be aware of and practice modern preventive health care. The low income of Chicanos makes the practice of preventive health care difficult.

-- The crowded housing and lack of basic services, such as water and treated sewers, results in a greater potential for some forms of communicable diseases among many Chicanos. Lack of these facilities also makes preventive health practices difficult.

Consequently, a system of health care delivery, including preventive health services and health education, which is designed for relatively well-educated and middle-income Anglos, will prbably not meet the needs of low-income Chicanos. Rather, the design of the appropriate health system must be predicated upon the health risks and health needs which exist in the population and built upon what currently exists.

We agree with the recognition of the authors of the report, as noted in their closing remarks, that the programs in these areas of Chicano population concentration should be designed with the existing health needs in mind and with the active involvement of the residents. This element is worthwhile mentioning several times. Bilingual/bicultural health education programs should take a key role in increasing the knowledge about health and health resources among Chicanos. But these efforts will be minimal compared to the level of need and resources required to meet those health needs, not only in South Texas but throughout the Southwest and the Nation where Hispanics reside.

There are marked differences in causes of death between Hispanics and Anglos which speak against the mere replication of preventive health efforts and for the need for Hispanics to participate in the planning, development, and monitoring of preventive programs and health care delivery in general. Of concern to us is their finding that "Mexican Americans appear to be dying of a relatively broader spectrum of ailments and conditions than are Anglos."

It is apparent from reading this report that the picture is the same for Hispanics throughout the country, and that a great many public and private resources must be marshalled and targeted towards Hispanics. This is a critical point if we are to improve the health of Hispanics not only in rural isolated areas but also in the low-income urban areas of the Southwest, as has been pointed out very clearly in the LBJ School of Public Affairs report.

A Special Report by the Center for Health Administration Studies, University of Chicago(1978), funded by the Robert Wood Johnson Foundation and the National Center for Health Services Research, Department of Health, Education, and Welfare, provides an added perspective regarding access to health care by

Hispanics. The report emphasizes dimensions of access which are: source, convenience, utilization, need, and satisfaction. Their study indicates that (a) there is a greater percentage of Chicanos in the Southwest without a regular source of health care (17 percent) than even Southern rural Blacks (10 percent) and the general U.S. population (12 percent); (b) 35 percent do not have any form of health insurance, compared to 12 percent of the general U.S. population; (c) 35 percent of Chicanos in the Southwest did not even see a doctor in that year, compared to 24 percent in the general population. The study further shows that Chicanos greatly underutilize dental services; 69 percent did not see a dentist in that year, compared to 51 percent of the general population. Moreover, a medical found that Chicanos in the Southwest see a doctor less often than estimated necessary compared with the general population. While these figures address the health conditions found in 1978, there are indications that these have not changed in the 1980's.

The statistics on the status of the Chicano in the Southwest point out we are a people who work and remain poor; a people in great need for the quality of health care available and accessible to most Americans and little money to purchase it. But we remain convinced and steadfast that the only road for the future of our health needs can best be met through a concerted and unified effort in the promotion of the development of Chicano consumer-controlled organized primary ambulatory systems of care. I will discuss with you what we consider to be the most important aspects of ambulatory care systems as well as the barriers and some suggestions for the removal of those barriers which impede the development of Community Health Centers (CMHC), Migrant Health Centers (MHC), and Health Maintenance Organizations (HMO).

The term "comprehensive health services," as I use it, refers to a broad spectrum of programs necessary to maintain a desirable quality of life, such as, but not limited to, medical, dental, and mental health; preventive and environmental health; and nursing and health education services. The intent of this approach is to promote serious concern and action in redesigning health service delivery systems to improve the quality of life of Hispanics.

Hospitalization

Community Health Centers and Migrant Health Centers have no access to the in-patient dollar. Therefore, the patient of a center is forced to pay out of his/her pocket for the necessary in-patient services. This is a barrier which reduces the capability of a center to provide quality comprehensive primary health care. It is in the best interest of the health care system that the in-patient dollar be in the hands of the organized ambulatory health setting, such as Community Health Centers and Migrant Health Centers. This control of the in-patient dollar would be similar to the Health Maintenance Organizations, a system which stresses preventive care and thus reduces the frequency of admissions and length of stay in hospitals. Karen Davis, writing in the Journal of Medical Education (January, 1977), states that: "Such centers have documented their cost effectiveness through improved health of patients and reduced hospitalization." Savings generated through cost-containment efforts of such programs should eventually be directed to address community health education needs and other preventive services.

If these organized systems of ambulatory health care are to be proven effective as a cost-containment mechanism, they must be developed with autonomy from the in-patient system of care (hospitals) in this country. If they are not separate and are developed under the auspices of the in-patient system, we run the risk of the in-patient system using these centers as "feeders" to ensure maximum occupancy rates.

Technical Assistance

Much technical assistance is needed in the development of comprehensive health care systems if Hispanics are to achieve the level of competence and quality of service delivery that we seek. Barriers are twofold, in that the model of organized, integrated, comprehensive primary health care systems is new to the Nation and that there are few Hispanic groups that have the capability for developing such systems.

The need is great for technical assistance to Hispanic groups to develop our own system of care. It is imperative that tehcnical assistance centers be in place, such as the San Antonio-based Rio Grande Federation of Health Centers, and be given substantial resources to bring to full capacity the few organized systems now in place and, just as important, to assist Hispanics in the development and implementation of new systems, in both urban and rural areas. This technical assistance has not been forthcoming, despite the fact that all regional offices, through congressional and departmental mandate, have been at some time under great pressure to develop rural and urban health initiatives. With inner city health initiative priorities, groups in the Hispanic rural communities have seen little on-site technical assistance.

Areas of critical need to Hispanics requiring technical assistance are:

1. Financial management
2. Clinical management, i.e., quality assurance
3. Management information systems
4. Organization and development
5. Board training
6. Consumer health education and prevention
7. Grantsmanship and program development

Medicare and Medicaid

It is interesting to note that while Medicare and Medicaid programs have been in part responsible for making financial access to health care a reality for many poor people, it seems that not all poor persons have the full benefit of these programs. At least that is the case in Texas and New Mexico. Medicaid, as administered by the States of Texas and New Mexico, recognizes only three categories of persons eligible for benefits under this program. These categories are Aid to Families with Dependent Children, aid to the blind, and aid to the permanently and totally disabled. In fact, Texas prides itself in that it spends less on poor people than almost all other States and is given to great amounts of rhetoric regarding the work ethic, for example, the "right to work" and providing incentives for working. By limiting the eligible population for Medicaid benefits to the above three categories, they may save a lot of money but they also severely limit the income options of poor people in Texas and New Mexico. There are great numbers of Chicano working poor in these States who are economically disadvantaged and medically needy. By setting income criteria for the receipt of benefits of the Medicaid program, we could alleviate much of the financial burden due to medical expenses of many medically-needy people.

The State of Texas goes further in limiting Chicanos' options regarding health care. While most other States do, Texas does not recognize reimbursement charges for any clinic services from ambulatory care or prepaid centers, thus restricting the development of our organized systems of ambulatory, primary health care. The State agency must be less restrictive in providing reimbursements if access and utilization by Hispanics are to increase.

Medicare for the Chicano elderly would work well if a sufficient number of doctors accepting Medicare assignments were accessible. However, there are still other barriers to proper health care for those who should benefit from Medicare provisions. For example, a doctor can assign a hospital bed to an infirm elderly person for use at home, but Medicare will not reimburse an assignment of special bedding for the prevention of bedsores until after the bedsores occur and the doctor orders the bedding. The patient suffers, but the system enriches itself at the patient's expense. There are other examples of contradictions, but the point is, Hispanic poor continue to suffer at the hands of a complex, often insensitive system.

Regional Office

Despite the significant attempts being made for the improvement of health care for Hispanics, the road ahead is rocky. There is a general feeling among Hispanic groups that this is one area in great need of improvement in order to initiate and implement changes that can improve the health care service delivery to Hispanics. This is based on the following:

- A dearth of Hispanics at high-level positions within PHS
- Insensitivity of public agencies to Hispanic programmatic concerns
- Lack of meaningful action by the Federal, regional, State, and local agencies in implementing mandates to develop community-based health care centers.

The formation of the South Texas Health Consumers Association was in direct response to the unwillingness of the established council of governments in our area to allow for an open and active participation by Chicanos. Though our application was favorably reviewed by the Area's 314 (b) agency and the Region's Objective Review Committee, we failed to get the designation. We knew something had happened along the way, and we were intent on finding out. So we filed a suit in the Federal District Court, Southern Division of Texas. This suit is styled, South Texas Health Consumer Association vs. Floyd Norman, Joseph Califano, et. al.

We are alleging that the Regional Health Administrator (RHA) acted in an "arbitrary and capricious" manner in having awarded the designation to our rival group. We have found out that the RHA and his staff completely bypassed the recommendations made by the 314 (b) agency and the Objective Review Commiteee. Our application was cited for three deficiencies; the rival group, with five. However, the major deficiencies were that we did not have the organized provider support; they did not have low-income and organized consumer support. In any event, it was our feeling then, as it is now, that the provider element would ultimately have had to join and work with whoever was designated.

When queried in a recent deposition about why HEW-PHS has set up an Objective Review Committee, providing countless hours of staff assistance to that committee, giving it voting powers and procedures, and then simply ignores that committee's advice, a regional officer responded that the committee's decision would be considered only if "everything else between competing applicants is equal"; and then he went on to say, "It's only advisory, we make the final decision anyway." When we asked the regional officer if the 314 (b) agency review meant anything or played into the region's decision, his response was even more questionable. He responded by saying that, since there were several 314 (b) agencies in that particular area, their recommendations offset each other. We reminded him that there was only one 314 (b) agency. Moreover, the Secretary's office had instructed the Regional Health Administrators, along with delegating the authority to select and designate applicants, to adhere to certain procedures when faced with conflicting resolutions. Detailed memoranda must be submitted to the file which would explain the RHA's decision to ignore the recommendations of his Objective Review Committee, stating whatever extenuating circumstances, if any, required him to take such action. Neither our interrogatories nor seven recent depositions have produced such information.

I don't mean to come here and try this case before you: first of all, I am not an attorney. But I do want you to have some familiarity with this case because it clearly demonstrates the barriers which Hispanics faced in attempts to make health services available and accessible. I think that you can understand the frustrations we must endure, the resources we must expend in litigaton, and the reasons why we are disillusioned.

In closing, I would like to leave you with a thought expressed by Franklin D. Roosevelt in 1932 but which is still applicable today:

> "The country needs and, unless I mistake its temper, the country demands bold, persistent experimentation. It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something."

And so, we must continue to pressure decisionmakers and program people to do "something," but try.

ISSUES ON HEALTH RESEARCH RELATED TO HISPANICS

1. "Hispanic Cultural Factors in Drug, Alcohol Abuse and Mental Health"

Esteban L. Olmedo, Ph.D.
American Psychological Association
Washington, D.C.

2. "Towards a More Fruitful Interaction Between the Hispanic Community and the National Institutes of Health"

L. Gabriel Navar, Ph.D.
University of Birmingham at Alabama
Birmingham, Alabama

"Hispanic Cultural Factors in Drug, Alcohol Abuse and Mental Health"[1]

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Hispanics constitute the second largest ethnic minority group in the United States and include persons of Mexican origin (Chicanos or Mexican Americans), Puerto Ricans, Cuban Americans, and persons of Central or South American origin. The 1980 census revealed that there were at the time at least 14.6 million "persons of Spanish origin" living in the United States (U.S. Department of Commerce, 1981). This number reflects an increase of 61 percent over the figure of 9.1 million reported for 1970. Although this increase may be attributed in part to improvements in the 1980 census procedures, demographic trends indicate that the Hispanic population is growing faster than the general U.S. population, and some researchers estimate that Hispanics will become the largest minority group in the not-too-distant future (e.g., Macias, 1977).

What is the mental health status of this large and rapidly growing population? Although it is difficult to answer this question directly, due to the lack of adequate epidemiological data for Hispanics, their plight as a population "at risk" has been well documented (Padilla & Ruiz, 1973; Padilla, Ruiz & Alvarez, 1975). Perhaps one of the most comprehensive assessments of the mental health status of Hispanics was provided by the President's Commission on Mental Health (1978). The Report of the Commission's Subpanel on Hispanics stated:

> "They (Hispanics) have been found to suffer the full impact of a 'culture of poverty' to a much higher extent than the general population. Low income, unemployment, underemployment, undereducation, poor housing, prejudice and discrimination and cultural/linguistic barriers have been compounded by the low quality and quantity of mental health services available to Hispanics. This situation has perpetuated undue stress on Hispanic Americans and often results in severe deleterious consequences not only for the Hispanic population, but also for American society at large. Increased prevalence of substance abuse, alcoholism and juvenile delinquency are the most obvious examples. Personal suffering and the extraordinary waste of human resources are more difficult to evaluate but are, nevertheless, equally important consequences to the social condition of Hispanics in the United States (pp. 905-906)."

Other factors listed in the Report included the following facts: most Hispanics (84 percent) reside in the metropolitan areas, such as the central cities of Los Angeles, New York, and Chicago; Hispanics are the youngest of all ethnic groups, having a median age of 20.7 years; 80 percent report Spanish as their mother tongue; and 20 percent report difficulty with English. Other indicators of interest pertaining particularly to Hispanic children and families were summarized by Olmedo (1981):

> ". . . Hispanic children are typically behind other students by two to three grades . . . only 30% complete high school. In urban areas . . . the dropout rate can be as high as 85%. In general, the school dropout rate for primnarily Spanish-speaking Hispanics is more than three times as high as the rate for primarily English-speaking Hispanic students. The cycle, as expected, is further manifested in the overall socioeconomic and occupational status of Hispanics. The median annual family

> income in 1978 was $12,600 for Hispanics versus $17,600 for the general population. Among Hispanics, only 8% held jobs of a professional or technical nature, as compared with 16% for non-Hispanics (pp. 1079-1080)."

Similar findings concerning the educational and occupational status of Chicanos were revealed by the 1979 Chicano survey conducted by Arce (Institute for Social Research, 1982). The survey found that 66 percent of Chicanos in the southwest and midwest of the United States had "completed less than 12 years of formal education, and 27 percent had fewer than 6 years of schooling . . . Nearly half (47 percent) of the Chicano households had family incomes of less than $10,000 in 1978 (p. 8)."

Although the foregoing discussion suggests a number of factors that place Hispanics at risk, there are no systematic data, national in scope, concerning the epidemiology of alcohol abuse, drug abuse, or mental health problems among this population.

With respect to alcohol abuse and alcoholism, what little information exists is usually indirect, local in nature, and based upon alcohol-related physical problems revealed by autopsies, reports of alcohol abuse among Hispanics seeking mental health services, and records of drunk-driving arrests (Alcocer, 1977). Information of this nature has resulted in estimates that place the rate of alcoholism for the Hispanic population at approximately 10 percent, or between 2.5 and 3.0 million (Garcia, 1976). Hall (1977) has also concluded from a critical review of the literature that alcohol abuse and alcoholism are greater among Hispanics than among Anglos or the general population. This author has pointed out, however, that there are significant differences among the various Hispanic subgroups not only in terms of prevalence of drinking problems but also with respect to related cultural characteristics.

The absence of systematic epidemiological data is also conspicuous with respect to other substance abuse. Nevertheless, some local studies indicate a higher prevalence of the problem among Hispanics than in the general U.S. population. For example, Padilla, Padilla, Morales, Olmedo, and Ramirez (1979) found the prevalence of inhalant abuse among Chicano barrio youth to be 14 times greater than that reported for a national probability sample of the same age cohort. The same study reported the prevalence of marijuana use to be over twice of that reported for the national sample.

With respect to the incidence and prevalence of mental illness among Hispanics, the President's Commission on Mental Health Report (1978) noted several problems with available data. One of the problems is that the data are usually confined to individuals who have sought treatment at local public facilities. Another problem has to do with the lack of information concerning the validity and/or reliability of assessment, diagnostic, and classification procedures for the Hispanic populations. Nevertheless, the Report concluded that:

> "Sampling and measurement biases notwithstanding, the available data suggest epidemiological patterns among Hispanic groups which are different from those of the Anglo population. For example, Mexican American patients have been found to exceed their expected frequency for incidence of schizophrenia, major affective disorders, neuroses, behavior disorders of childhood and adolescence, nonpsychotic organic brain syndromes and mental retardation . . . (p. 927)."

The foregoing introductory discussion has sketched out the significance and uniqueness of the Hispanic population in the U.S., as well as its special status vis-a-vis alcohol, drug abuse, and mental health problems. The remainder of this paper is devoted to (a) exploring some important issues in the utilization of services by Hispanics; (b) presenting a theoretical framework for the identification and assessment of cultural variables; and (c) discussing some resultant implications for research, training, and service delivery as they pertain to Hispanics in the U.S.

UTILIZATION OF SERVICES

Although the socioeconomic status of Hispanics would suggest that they, as a group, are under greater psychological and emotional stress, they tend to underutilize the mental health services that are available. Although utilization rates vary as a function of subgroup and geographic location, the data available indicate that Hispanics are often represented among recipients of services at rates that are 50 percent or less than their representation in the general population (Brandon, 1975; Kruger, 1974; President's Commission on Mental Health, 1978). The fact that Hispanics receive mental health care of lower quantity and quality than other U.S. citizens has been extensively documented (Camayd-Freixas, 1982; Karno & Edgerton, 1969; Padilla & Ruiz, 1973; Padilla, Ruiz & Alvarez, 1975; Padilla, Carlos & Keefe, 1976). Several hypotheses have been formulated to account for this empirical finding:

1. Lower frequency and severity of mental illness due to cultural characteristics, such as the extended family system, which provide protection against emotional stresses (Jaco, 1959, 1960; Madsen, 1964).

2. Utilization of curanderos ("faith" healers) and "folk" medicine instead of conventional psychotherapists (Creson, McKinley & Evans, 1969; Edgerton, Karno & Fernandez, 1970; Garrison, 1975; Kiev, 1968; Lubchansky, Ergi & Stokes, 1970).

3. Reliance upon relatives, compadres, friends, physicians, and priests or ministers in dealing with emotional problems (Padilla & Ruiz, 1973; Padilla et al., 1975, 1976).

4. Discouraging institutional policies, such as geographic isolation from centers where services are delivered, language barriers, class-bound values, and culture-bound values (Padilla & Ruiz, 1973; Padilla et al., 1975, 1976).

The first two hypotheses are now considered untenable on the basis of empirical findings (Padilla & Ruiz, 1973; Padilla et al., 1975). The last two, however, have received considerable support (Kline, 1969; Miranda, Andujo, Caballero, Guerrero & Ramos, 1976; Padilla et al., 1976; Torrey, 1972). It should be emphasized that these two explanations are not mutually exclusive. In fact, it would seem quite reasonable that discouraging institutional policies could be responsible, at least in part, for increased reliance on alternative sources of help for emotional problems.

Perhaps the most critical aspect of institutional policy that is detrimental to the Hispanic client pertains to basic differences between the client's cultural background and the culture emobodied in institutional personnel and policy. This "cultural conflict" has been shown to adversely affect diagnosis, treatment, and therapy outcome.

Diagnosis. Two issues sensitive to cultural differences are involved here: (a) the use of projective and objective diagnostic instruments whose validity for Hispanics has not been established, and (b) what Padilla and Ruiz (1973) call the "inherent probability of professional misjudgment" (p. 19) on the part of the therapist when the client has a different cultural background.

With respect to the first issue, Padilla and Ruiz (1975) have indicated that although little research is available on personality assessment of Hispanics, the evidence suggests that they might differ in response patterning on the Rorschach and Thematic Appreciation Test (TAT), and that language problems may contaminate the interpretation of data from objective instruments such as the California Psychology Inventory (CPI) and the Minnesota Multiphasic Personality Inventory (MMPI). In addition, Turner and Horn (1975) found that Mexican Americans showed distinctive patterns of responding to the Guilford-Zimmerman Temperament Survey and the Kuder Occupational Interest Survey. The lack of data in this area suggests a pressing need to validate clinical diagnosis instruments for the Hispanic population (Olmedo, 1977).

With respect to the second issue, Torrey (1972) illustrated the point by reporting a study in which 90 percent of Anglo psychiatric residents associated the phrase "hear voices" with the term "crazy," while the association was made by only 16 percent of the Mexican-American high school students. Potential diagnostic bias due to cultural conflict has also been discussed by Bloombaum, Yamamoto, and James (1968); Kline (1969); Marcos, Alpert, Urcuyo, and Kesselman (1973); and Padilla, Olmedo, and Loya (1982).

Treatment. There is substantial evidence indicating that the type and quality of treatment for Hispanics is inferior as a result of their cultural background. Yamamoto, James, and Palley (1968) conducted a study comparing psychiatric care for Caucasians, Blacks, Mexican Americans, and Asians at the Los Angeles County General Hospital Outpatient Clinic. The results indicated that Hispanics, when compared with Caucasian controls, were less often referred for individual or group psychotherapy and more likely to be referred to the "Follow-up Clinic" to see a doctor and have drugs prescribed. In addition, they terminated sooner due to attrition or absence of recommendation for continued therapy. Similar findings have also been reported by Karno (1966).

Another group of related studies dealing with social class (Lorion, 1973, 1974; Cobb, 1972) indicates that, due to cultural conflict between middle-class therapists and lower-class clients, whatever little treatment is provided to the latter may be totally inadequate. With this respect, Padilla et al. (1975), concluded:

> "First, race and social class of the therapist seem to affect the patient's response to treatment; and second, an effective and appropriate 'solution' to the problem based upon middle-class values may be totally inappropriate and ineffective for a patient returning to his lower-class environment (p. 897)."

Since Hispanic clients are likely to come from a lower-class environment (Padilla & Ruiz, 1973), it is apparent that in their case cultural differences and socioeconomic status jointly result in little treatment of inferior quality.

Outcome. In view of the problems reviewed above pertaining to diagnosis and treatment, it is not surprising to find that a typical "therapeutic" outcome for Hispanics is premature termination of treatment (Camayd-Freixas, 1982; Miranda et al., 1976; Yamamoto et al., 1968). This constitutes prima facie evidence that psychotherapy, in general, results in a negative outcome for Hispanic clients when the therapeutic encounter takes place under conditions of cultural conflict (Abad, Ramos & Boyce, 1973; Kline, 1969; Torrey, 1972).

Findings of this nature have resulted in the recent formulation and implementation of a limited number of culturally-relevant models of mental health service to the Hispanic population (see Padilla et al., 1975, for a description of these models; other successful approaches have been described by Casas, 1976; Herrera & Sanchez, 1976; and the President's Commission on Mental Health, 1978). In general, these approaches attempt to improve mental health service delivery by reducing or eliminating sources of cultural conflict prevalent in traditional settings. This has been accomplished through specialized training of professional and paraprofessional staff, utilization of bilingual/bicultural personnel, development of family-oriented group psychotherapies, and the establishment of barrio service centers (Padilla et al., 1975).

A THEORETICAL FRAMEWORK FOR THE IDENTIFICATION AND ASSEMENT OF CULTURAL VARIABLES

A common shortcoming of studies investigating the relationship of cultural variables to mental health has been the failure to properly consider the issue of variability within the Hispanic population. Typically, culture has been operationally defined in terms of ethnic group membership, largely ignoring intragroup variance. There is substantial literature, however, indicating that Hispanics are not a homogeneous cultural group (Murillo, 1976; Olmedo, 1979; Padilla & Ruiz, 1973 ; Ramirez & Castaneda, 1974). Within this context, Hispanic-Anglo dichotomies are of limited value in understanding the role of cultural background in mental health. More useful, instead, are definitions of acculturation that reflect the degree to which Hispanics share various sociocultural characteristics of the mainstream group. Quantitative measures of this process could then provide a more appropriate basis for establishing the relevance of culture to Hispanic mental health (Olmedo; J.L. Martinez, Jr.; & S. R. Martinez, 1978).

There are few studies that have attempted to relate quantitatively-defined acculturation to mental health issues. Miranda et al. (1976) found that female Mexican Americans who remained in therapy for a minimum of five sessions showed significantly higher acculturation than those who terminated therapy prematurely. Warren, Olmedo, and Go (1976) found that more-acculturated Mexican Americans showed more positive attitudes toward professional counseling and psychotherapy than less-acculturated Mexican Americans. This relationship held true regardless of sex or age. Another interesting finding of this study was that highly-acculturated Mexican-American females exhibited more manifest anxiety than Mexican-American females scoring low in acculturation and Mexican-American males with either high or low acculturation.

Although the aforementioned studies suggested that acculturation may be a most important variable pertaining to the mental health of Hispanic individuals, neither investigation used a measure of acculturation with known fundamental psychometric properties such as validity, reliability, and normative standards. To the best knowledge of this author, few studies of this type have been conducted using such a measure. This is a most significant area of Hispanic mental health in which little scientific evidence is available.

The direct relevance of this issue to psychotherapy with Hispanic clients has been well stated by Casas (1976):

> "Though emphasis has been given to the importance of positive recognition and use of the person's culture . . . the therapist is cautioned against overreacting to general cultural attributes and inaccurately assuming that all Spanish-speaking individuals are alike. One cannot assume that if a therapy approach works for one it will work for all. Making such an erroneous assumption may result in the perpetuation of inadequate therapy for the individual in question as well as the population in general (p. 65)."

Some recent developments in the theory and measurement of acculturation have, I believe, important implications for the proper identification and assessment of cultural variables. These developments concern attempts to research cultural differences (or similarities) within the scope of a comprehensive theoretical framework that focuses on the status of the individual vis-a-vis multiple cultural dimensions.

The theoretical frameowrk has been presented in detail elsewhere (Olmedo, 1979, 1980; Olmedo & Martinez, 1978; Padilla, 1980) but will be briefly summarized here. In essence, acculturation is conceptualized as a complex process which is multidimensional in nature. Some dimensions may be correlated with each other, while others may be orthogonal. By the use of psychometric procedures, quantitative indicators (or scales) can be developed for each of the hypothesized dimensions. On the basis of scores on these scales, individuals of various cultural groups or subgroups can be placed on a cultural continuum or in a cultural space. If a single dimension is assessed, then a single-scale score places the individual on a continuum whose opposite poles are defined by the cultures in contact. If multiple dimensions are assessed, then it is possible to locate the individual in a Euclidian cultural space defined by dimensions which represent variability among the cultures in contact.

As would be expected, different investigators have used different items or variables in constructing scales designed to tap various dimensions of acculturation. These variables, however, can be classified in terms of three major categories: (a) linguistic, (b) psychological, and (c) sociocultural (Olmedo, 1979). Most acculturation measures include items designed to assess language characteristics, such as, for example, proficiency, preference and/or use of Spanish versus English (Cuellar, Harris & Jasso, 1980; Olmedo & Padilla, 1978; Padilla, 1980; Szapocznik, Scopetta, Kurtines & Arnalde, 1978). Psychological items are designed to assess "ethnic identity" as manifested by cultural values, attitudes, or behaviors that can be identified with different cultural groups (Clark, Kaufman & Pierce, 1976; Padilla, 1980; Pierce, Clark & Kiefer, 1972; Ramirez, Castaneda & Harold, 1974; Szapocznik et al., 1978). The third category of items is sociocultural in nature and includes demographic characteristics such as socioeconomic status and mobility, family size and structure, degree of urbanization, etc. (Berry & Annis, 1974; Mercer, 1976; Olmedo et al., 1978).

Beyond differences in the types of items used, acculturation measures have been developed using various procedures for item selection and validation. Items may be selected on the basis of how well they discriminate between cultural groups, or constructed to tap hypothesized acculturation or ethnic identity factors. In terms of validation strategies, acculturation scales have been correlated with ethnic group membership, number of years in the U.S., and generation of respondent. In addition, the construct validity of some measures has been established by factor analytic procedures (Olmedo, 1979; Padilla, 1980).

What are the empirical findings that bear upon the theoretical framework and associated operational procedures described above? Olmedo (1979) summarized the main results of psychometrically-oriented research on acculturation. Essentially, the results indicated that acculturation is a multidimensional construct that can be reliably and validly measured. In terms of *reliability*, factorially-derived measures have been shown to be internally consistent with alpha cooefficients between .90 and .98 for linguistic, behavioral and sociocultural scales, and alpha coefficients between .76 and .86 for attitudinal and value orientation scales. Acculturation measures also tend to be stable over time, as indicated by test-retest reliability coefficients ranging between .84 and .96 over 2-4 weeks. In terms of *criterion-related validity*, acculturation measures have been found to yield correlations between .66 and .85 with ethnic group membership, between .54 and .83 with generation, and .61 with number of years in the U.S. (Olmedo et al., 1978; Olmedo, 1979; Padilla, 1980; Szapocznik et al., 1978). *Concurrent validity* studies have also been encouraging, showing correlations between .76 and .81 among various measures developed independently by several investigators (see, for example, Cuellar et al., 1980).

With respect to the multidimensionality of acculturation, Olmedo (1979) has noted that factor-analytic studies conducted by independent investigators and involving various Hispanic, Asian, and Anglo groups tend to suggest the existence of at least three major or global dimensions of acculturation. The first dimension is defined primarily by linguistic variables and knowledge of "cultural-specific" traditions, customs, and preferences. This dimension has been labeled "Cultural Awareness" (Padilla, 1980), "Acculturative Balance" (Clark et al., 1976), "Behavioral Acculturation" (Szapocznik et al., 1978), and "Nationality-Language" (Olmedo et al., 1978). A second dimension, which has been labeled "Ethnic Loyalty" (Padilla, 1980), "Traditional Orientation" (Clark et al., 1976) and "Value Acculturation" (Szapocznik et al., 1978), seems to be defined in terms of how much individuals identify themselves with their original culture and actually adhere to customs and traditions particularly as they pertain to the family. A third dimension, labeled "SES," emerges in factor-analytic studies that include sociocultural variables (Mercer, 1976; Olmedo et al., 1978), and reflects educational level and occupational status of the respondent or the respondent's household. These dimensions are generally independent of each other or only moderately correlated. For example, Olmedo et al. (1978) have reported a correlation of .21 between SES and Nationality-Language, and Padilla (1980) has reported a correlation of .37 between the factors of Cultural Awareness and Ethnic Loyalty.

IMPLICATIONS FOR RESEARCH, TRAINING, AND SERVICE DELIVERY

Probably the first comprehensive review of the Hispanic mental health literature was conducted by Padilla and Ruiz (1973). These authors provided a critical assessment of the some 500 articles and books that constituted the literature at the time. Some common deficiencies were the prevalence of poor methodology and data analysis, the abundance of stereotypic interpretations of Hispanic cultures, and the lack of programmatic research and replicability of findings. Since then, the research and literature in the field have greatly expanded. For example, a recent bibliography (Newton, Olmedo & Padilla, 1982) contains over 2,000 citations. The quality of the research, however, continues to be in need of improvement. The President's Commission on Mental Health (1978) provided the following assessment of research in the field:

> "Typically, research with Hispanics has involved a qualitative definition of culture in terms of group membership (Mexican American, Puerto Rican, Cuban, etc.). Subjects are then asked to complete a task, a questionnaire, or a battery of psychological tests. Sometimes their performance is compared with that of other ethnic groups, especially the majority group. The results are then generalized to the entire ethnic group under consideration. In those rare instances where the research design is explicitly sensitive to intragroup heterogeneity, the variables most often manipulated have been generation of respondent, age, sex, language proficiency and/or preference, and geographic residency. Finally, comparative studies have typically used univariate approaches in which cultural differences are assessed by means of a single variable or, at best, a very limited set of variables. The implications of differences on other variables, which may or may not be interrelated, is not investigated in a systematic fashion. Furthermore, the cross-cultural validity of measurement instruments is rarely tested (p. 920)."

Recent acculturation research, as described above, suggests that the extent and complexity of cultural differences among Hispanics seriously limit the heuristic value and validity of group-oriented generalizations. A more useful framework is provided by examining the status of individual Hispanics vis-a-vis levels and kinds of acculturation. We are now in a position to go beyond the search for a single model of research, training, or service delivery for Hispanics. All indications are that the process of acculturation is much more complex than anticipated, and that paradigms based on Anglo-Hispanic dichotomies do not provide an adequate basis for incorporating the "cultural variable" in research, training, or service delivery (Cuellar et al., 1980; Kranau, Green & Valencia-Weber, 1982; Padilla et al., 1982; Szapocznik & Kurtines, 1980).

It also appears that research on individual acculturation will be conducive to a better understanding of "cultural differences" in scores from personality and clinical assessment instruments. For example, an exploratory study of the relationship of factorially-derived acculturation dimensions to MMPI scores of Anglo and Chicano college students has yielded some interesting preliminary findings (Padilla et al., 1982). Canonical correlation analyses have resulted in two orthogonal sets of significantly related canonical variates. In the first set, the "acculturation" dimension was defined by linguistic and generational variables and the "clinical" dimension was defined by the L, Hs and Mf scales. Later generation, English-speaking individuals tended to score higher on the Mf scale and lower on the L and Hs scales. Conversely, earlier generation, Spanish-speaking individuals tended to score higher on the L and Hs scales and lower on the Mf scale. With respect to the second set of canonical variates, the "acculturation" dimension was defined by socioeconomic status and the degree of "potency" ascribed to the concept "male." The clinical dimension was defined by the L, K, and Pd scales. Higher SES individuals who ascribed less potency to the conept "male" tended to score higher on the L and K scales and lower on the Pd scale. Conversely, lower SES individuals who ascribed more potency to the concept "male" tended to score lower on the L and K scales and higher on the Pd scale. These preliminary findings, although obviously in need of cross-validation, are in general agreement with what might be expected on the basis of previous findings concerning Anglo-Chicano as well as socioeconomic status differences in MMPI scores (Lachar, 1974; Plemons, 1977; Reilley & Knight, 1970).

With respect to Hispanic alcohol abuse and alcoholism, Madsen (1964) found that the agringado alcoholic (i.e., the acculturated Mexican-American alcoholic) experiences value conflicts from loss of identity and community. Additionally, Pearson (1964) reported that nonacculturated Chicanos have significantly higher rates of rehabilitation from alcoholism than do acculturated Chicanos. Graves (1967) found that nonacculturated Hispanics internalize familiar and religious controls which result in lower rates of alcoholism; thus, as the influence of family and church begins to break down through acculturation, the incidence of alcoholism increases. Recent research, however, has shown that, at least with respect to Hispanic adolescents, prediction of alcohol use and abuse from cultural and background variables is complex, with the latter accounting for only 12 percent to 22 percent of the variance in the former (Estrada, Rabow & Watts, 1982; Padilla et al., 1979).

In terms of drug abuse and mental health issues, Szapocznik and associates (Szapocznik & Kurtines, 1980; Szapocznik, Scopetta & King, 1978) have conducted extensive research on the complex relationships involving acculturation, biculturalism, psychological adjustment, and drug abuse. On the basis of their findings, they have developed a psychosocial model of acculturation for research and service delivery targeted to the Cuban-American population. They have found that the development of marked intergenerational differences in behavioral acculturation are critical to the etiology of family disruption among Cuban immigrants and the subsequent emergence of behavioral disorders among the young, such as drug abuse and antisocial behavior. These findings have led to the development of "Ecological Structural Family Therapy" techniques successful in the treatment of acculturation-related dysfunctions. The process is aimed at restoring the familial lineal system of functioning and promoting the reapproachment between the alienated parent or parents and the problem youngster.

Finally, recent acculturation research suggests some important implications for training models designed to prepare professionals and paraprofessionals who will provide services to Hispanics. Many practitioners, including Hispanics, have found that the acculturating pressures encountered throughout their formal training have resulted in significant conflicts in cultural identity and subsequent alienation from their respective ethnic communities. A study by Lopez (1977) provided some interesting empirical evidence bearing on this issue. The study consisted of a survey of Chicano and Anglo mental health service providers (psychiatrists, psychologists, and social workers) which assessed the presence of cultural stereotypes in clinical judgment. The results indicated that the sampled clinicians held various stereotypic notions about Chicanos which are empirically unfounded. For example, they judged Chicanos to be less aggressive, less independent, less leadership-oriented and more submissive than Anglos. Also, they considered Chicanos to be more emotional, spiritually-oriented and superstitious, but less practical and punctual than Anglos. The interesting aspect of Lopez's findings is that clinicians held these stereotypes regardless of their own ethnic background and experience. Judgment by Chicano bilingual therapists were just as stereotypical as those by Anglo monolingual therapists. In other words, a Spanish surname does not a culturally-sensitive clinician make!

It appears then that therapist dimensions of acculturation and ethnic identity are important parameters in need of further research. In particular, we need to know how these parameters are affected by current formal training programs, and what the consequences are vis-a-vis the future effectiveness of professionals for providing services to their ethnic communities. The commonly-made assumption that matching client and therapist in terms of ethnicity resolves the problem of cultural barriers should be critically examined in light of recent findings.

Summary and Conclusions. Hispanic Americans constitute a significant and rapidly-growing ethnic minority in our Nation. There are a number of stress indicators which place Hispanics, as a group, "at risk" with respect to alcoholism, drug abuse, and mental health problems. Although little systematic epidemiological data exist at the national level, local studies suggest that the prevalence of these problems is higher among Hispanics than among the general U.S. population. Nevertheless, they underutilize the services available, particularly when these services are not provided within a cultural context congruent with Hispanic heritage.

Anglo-Hispanic comparisons are useful at the descriptive level, for they suggest the presence of "cultural differences" that may require differential approaches to research, training, and service delivery. However, I have shown that the remarkable cultural heterogeneity that exists among Hispanics seriously limits the explanatory value of between-group comparisons. In addition, it also curtails the heuristic import of these comparisons vis-a-vis applied implications for the field of alcoholism, drug abuse, and mental health.

Recent theoretical developments and empirical findings in the study of individual acculturation confirm the magnitude and complexity of cultural variability within contemporary American society in general, and among Hispanics in particular. These developments also suggest that in order to increase our understanding of the role of the "cultural variable" in alcoholism, drug abuse, and mental health among Hispanics, we must look beyond ethnic group membership. More promising to the development and implementation of culturally-sensitive training models and service delivery systems is an approach based on the careful assessment of individual differences in acculturation, assimilation and ethnic identity. The evidence I have presented suggests that such an assessment should occur within the context of a multidimensional conceptual framework which takes into account linguistic, psychological, and sociocultural factors as well as their complex interactions.

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[1] The views expressed in this paper are solely those of the author, and do not necessarily reflect the policies of the American Psychological Association which can only be set by the Council of Representatives.

"Toward a More Fruitful Interaction Between the Hispanic Community and the National Institutes of Health"

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University of Alabama at Birmingham

The main objectives of this presentation are to identify the barriers and suggest means by which the National Institutes of Health (NIH) can (a) increase the participation of Hispanics in health-related biomedical research, and (b) increase the benefits derived by Hispanics from the activities and research of the National Institutes of Health.

It is difficult to decide on the best approach to initiate a dialogue in this area, since the issues evoke strong emotional reactions. An approach that may be more productive involves the discussion of the rationale for selecting the objectives of this presentation and the identification of specific activities of importance to the health status of Hispanics that could be supported by the various components of the National Institutes of Health.

Some of you are probably asking why a member of the faculty of the University of Alabama at Birmingham is making this type of presentation on this particular occasion, assuming that we know little about the health status and relevant research issues to Hispanics. If I am so concerned about the plight of Hispanics and its relationship to biomedical research, why am I not associated with another institution that could have a greater impact on Hispanic health issues? Some comments about myself might be in order to illustrate the typical career development pattern of most Hispanics in the health-related sciences and why I was asked to make this presentation.

It might be worthwhile to review the circuitous and indirect path that finally led me to my present career choice and position. In my earlier years in El Paso, Texas, I had little contact with anything related to science or medicine. I cannot remember a relative or family friend who was involved in any type of scientific endeavor or who knew anything about health-related research or health-related policies. To most of us, Washington, D.C. was a far and distant place where people whom we neither knew nor influenced made the laws by which we had to live. I became interested in agriculture simply because my father was involved in farming. However, for some reason I seemed to enjoy my high school science and mathematics courses. I did plan to go on to college and to study agriculture or enter some field associated with agriculture. Following my father's advice, I decided to enter veterinary school, an acceptable profession to me due to its association with agriculture and because it would allow me to pursue in more depth my scientific interests. It was only after two years in veterinary school that I recognized my preference for the rigorous biomedical courses, such as physiology, pharmacology, microbiology, and neurobiology. I finally decided to pursue a career in scientific research. Since physiology was my favorite course, I investigated graduate schools with strong physiology programs. After having the opportunity to study under Dr. Guyton at the University of Mississippi, Jackson, Mississippi, I developed an interest in renal physiology and the role of the kidney in the regulation of body fluid volumes.

My background actually is not typical of an average Mexican American from the southwestern portion of the U.S. If it had been more typical, I simply might not have entered a career in science. The lack of role models and serious economic disadvantages which create severe personal hardship do not lead to conditions favorable to becoming interested in a scientific career. Those Mexican Americans who have entered a career in biomedical research have done it indirectly; for most, the attrition rate is very high.

There are several types of problems that prevent the participation of underrepresented minority groups in scientific research. Some problems are related to philosophical issues; others, to the economic conditions which these groups face; and still others, to the many environmental problems encountered, including the absence of role models and discrimination.

The philosophical issues quite often evoke a great deal of controversy and emotion. This is particularly true among many members of the scientific community, who rationalize their rather myopic view through the belief that good science is good science no matter who does it and that it should be supported strictly on the basis of how good that science is judged by them to be. We fully recognize that many of our colleagues are disturbed to think that agencies such as the National Institutes of Health would "deteriorate" or "corrupt" if other than the criterion of "excellence" in science would be used in their activities. As long as there are major endeavors of great national significance from which the participation of a substantial portion of the population is excluded, for whatever reason, we are doing an injustice not only to the excluded but collectively to ourselves. When a group of people develops an attitude that differentiates between groups which have power, money and influence, and who represent the law and decisionmakers, from those who are powerless, there will be resentment, animosity and misunderstanding. Discussion of the "US" versus "THEM" syndrome is often neglected in the scientific community; and, in my opinion, it must be discussed, for it is central to the resolution of many of our problems in the field.

The second type of problems is related to the economic disadvantages and hardships that often lead to a nonstimulating environment. This type of problems is discussed more often and more overtly and in all probablility applies uniformly to most minority groups, including Hispanics. Even in this country, where there is general abundance, those who are brought up in areas of considerable economic deprivation have a negligible chance of overcoming their environment and becoming successful in a career of science and/or biomedical research. I strongly believe that this is the single major reason for the small pool of Hispanic college students able to enter careers in the health sciences and allied health professions. The academic foundations which as well provide certain skills to succeed in college and master the science courses, the supports and recourses required to enter these professions, are more often than not unavailable to minorities.

The third critical factor that determines success in any field is the all important availability of role models with which Hispanics can identify. In the situation with Hispanic students it is much more complex than with the Blacks, simply because there are a substantial number of colleges and universities, which have a high Black student population as well as substantial numbers of

Black faculty and administrators, that are dedicated to the education of Blacks. The Black student can identify with the college president and the members of the board, who are also Black. On the other hand, the Puerto Rican student in New York and the Chicano student in Dallas know that, while there are some Hispanic students in the particular college or university where they are students, there are only an occasional faculty member, a rare science faculty member, and no administrators with whom they can relate and identify.

Without role models, it is very difficult to motivate young people to enter the various professions. There is only a handful of native-born Hispanic American scientists, and they are scattered throughout the four corners of the United States. I should emphasize that quite often the Hispanic scientist is not in the institution of choice. We have to take positions where the best opportunities for scientific and professional development are offered. However, there is a general belief that Hispanic American scientists are not aggressively recruited by institutions where they could have the greatest influence. Many of us have felt certain subtle influences which make it more difficult for a Hispanic scientist to join prestigious institutions that are located in areas where there are significant numbers of Hispanics. If indeed this is true, then this is a serious problem and should be corrected.

I should emphasize that I am not suggesting that all Hispanic scientists should work only at institutions where there is a large number of Hispanic students. But it does seem that such institutions should be eager to employ more Hispanics. My personal experience has led me to believe that at present most institutions which have a high enrollment of Hispanic students, or which are located in areas where there is a substantial Hispanic population, are not making a serious effort to increase the number of Hispanic faculty members. Furthermore, I feel that this is particularly true in institutions that have health-related schools. Unfortunately, those few individuals who are hired often find themselves in a position which handles the activities of the office of minority student affairs. While this is an important task, Hispanic scientists want to be included in the mainstream activities of their institutions.

Hispanic Americans have a unique problem because they remain geographically scattered. In addition, there are many different groups, so that any potential influence that could be exerted simply by total numbers becomes so diluted as to be almost insignificant. How can we really expect the Chicanos, with population centers in the Southwest and with the mother country just across the Rio Grande, to identify with the problems of the mainland Puerto Ricans centralized in New York, or of the Cubans located mostly in Florida? Furthermore, how can you explain to the individual with a South American background, who immigrated to the United States as a mature adult, an already recognized scientist, the problem of growing up in an environment that continually reminds and often ridicules you because of your background and heritage? We must also recognize that the inclusion of such Spanish-surnamed scientists with the Hispanic statistics simply covers up the fact that the educational system in our country has produced a mere handful of Hispanic American scientists. We have brought them from other countries, but we have not produced them. We must recognize that Hispanics simply do not fall into one neat category, and different approaches must be developed to deal with this diversity.

It is clear that there is much that should and must be done; it seems essential that special efforts be made to inform members of the Hispanic communities of the many opportunities that are available for careers in the health-related sciences and to let them know that their contributions are desired, needed, and, in fact, expected. As I see it, it is our duty and responsibility, not our pleasure, to increase the participation of minorities in the mainstream activities of the scientific arena. We must continue to emphasize this point, and hope that we can raise the sensitivity of enough individuals with influence and a willngness to help. In particular, we need to reach those individuals in "middle management" who are often responsible for the implementation of programs. Unless they appreciate the significance of these programs, they will be less willing to exert their maximum effort in implementing them. If people view the minority assistance programs as simply being politically expedient and something that we just have to learn to live with, rather than being indicative of a fundamental commitment, then these programs will be viewed primarily as a separate effort that can best be handled by keeping them out of the mainstream activities.

I would like to say a few words about possible actions to improve the situation that I have been describing. I believe that one of our immediate goals should be to do everything possible to increase the number of individuals in the health sciences who can relate to Hispanics. These individuals should have a maximum degree of visibility and exposure so that they can become role models. Furthermore, if we are going to increase the opportunities for people from disadvantaged and economically deprived areas to enter the health-related professions, it is vital that programs which reach the youngsters while they are still in their formative years be developed. We will not be successful if we continue to wait until young people are in college and then encourage and motivate them to choose careers in biomedical science; it is too late then and the successes will be minimal. If during their crucial years such youngsters can associate with and be exposed to members of the scientific community, the pool of potential minority health professionals could be increased. I recognize that this is truly a monumental task which can only be achieved in stages and over several generations. However, at the very least, we should attempt to encourage science teachers to dedicate themselves to teaching science under the most difficult circumstances. It would be beneficial to develop programs that provide assistance to science teachers and to teachers of the teachers. If these science teachers could associate with those invovled in health-related disciplines, they in turn could become links to the students.

A critical factor for the success of strategies to attract Hispanics to the health-related professions is the expeditious training of Hispanic science teachers. The early and rapid training of greater numbers of Hispanic science teachers becomes a critical objective to be achieved with expedience. If young Hispanics do not choose science as a career, then there will not be role models; and the vicious cycle will continue unless some effective and aggressive program is implemented which can increase by a significant amount the number of Hispanics who are entering careers related to the biomedical sciences.

The question today is, "What can NIH do now and in the immediate future to contribute in breaking this vicious cycle?" What is the best approach by which NIH can contribute fo further the solution of the specific dilemmas faced by

Hispanics? We should not disregard the efforts which are currently being made toward the overall goal of increasing the numbers of science personnel from underrepresented minority groups. These programs are to be commended and highly regarded. Those programs with which I am most familiar and which I feel deserve special mention are:

1. The Minority Biomedical Support Program run by the Division of Research Resources,

2. The Minority Access to Research Careers Program under the auspices of the National Institute of General Medical Sciences, and

3. The Minority Hypertension Research Development Summer Program initiated by the National Heart, Lung, and Blood Institute.

These targeted programs have the goals of increasing the number of minority investigators in areas of relevance to the biomedical sciences, and of further developing the potential of available investigators. These efforts, while commendable, should only be regarded as the beginning of a serious attempt to increase participation of Hispanic Americans in health-related sciences.

It might be helpful to consider at this point a few specific ways by which NIH could contribute to the resolution of some of the problems that I have delineated. What can be done that has not or is not being done? Let's focus on a few questions that might serve as major discussion points.

Aside from the special programs which have been mentioned previously, an effort should be made to include a reasonable number of the Hispanic scientists in the mainstream activities of the NIH. For example, Hispanics should be recruited to positions where they can participate in various aspects of policy design and decision. If this is not happening, an analogy could be made to the medical school which has a single minority faculty member on its staff, whose duty is to be in charge of the affirmative action office, or the office of minority students. Greater efforts should be made to include Hispanics in positions which cut across various disciplines. Such efforts would allow Hispanics to exert a greater influence in the mainstream activities of the NIH.

Efforts should be made to identify and create a pool of notable Hispanic scientists to be appointed to study sections, review groups, advisory committees, or as consultants. This is necessary in order to demonstrate that there is in fact a sincere effort to weave the participation of minority scientists into the general fabric of NIH. It must be recognized that minority scientists usually are not associated with the highly prestigious institutions and do not always have the influential connections to reach those who decide on appointees to the above-mentioned internal groups and committees. Minority scientists are not acquainted with the NIH "system," and less, how to use it for their professional advantage or how to make it change to benefit their own excluded population group. There is general agreement that productive minority scientists are often kept at "arm's length" from the mainstream activities of NIH. This situation is similar to that encountered at university levels where administrators avoid giving positions of administrative authority to minority faculty, unless these positions are related to minority affairs.

DIALOGUE ON HEALTH

Workshops:

1. Hispanic Health Manpower Development

2. Utilization and Access to Health Care

3. Research Related to Hispanic Health Status

4. The Health Planning Process

5. Hispanic Health Statistics

Workshops

1. Hispanic Health Manpower Development

Discussants: Pedro J. Lecca, Ph.D.
Miguel A. Medina, Ph.D.
Francisco Velasquez

The main objective of this workshop was to identify programs and resources in the public health service that address the underrepresentation of Hispanics in the allied health professions, and to make recommendations and suggestions that would enhance Federal support for these programs. The workshop discussants emphasized the need to train health practitioners servicing Hispanic populations with a thorough understanding and sensitivity to the linguistic and sociocultural characteristics of these populations.

The workshop discussants assessed program strategies for recruiting Hispanics to enter the health professions. Such strategies as health fairs and career days, educational counseling, academic tutoring, teaching study skills, financial aid information, summer support programs, and the use of role models were cited as being effective when properly planned and implemented. Another important strategy for increasing the pool of Hispanic health professionals is early academic preparation and motivation, since many students drop out due to inadequate counseling and lack motivation in the middle school years.

It was noted that a bureaucratic obstacle in allocating resources to various Hispanic programs is the lack of adequate data base, often resulting in an undercount of Hispanics which adversely affects the allocation process when it is based on population proportions. The urgent need to increase Hispanic health manpower takes on additional significance as the number of Hispanics in the United States increases.

The Bakke decision was seen as an obstacle to minority manpower development because of the court's middle-of-the-road position which encourages reverse discrimination suits.

In the Southwest, in particular, Hispanics are faced with an insufficient supply of medical doctors and dentists. The problem is one of shortage in the rural areas and maldistribution in the urban areas. In South Texas, for example, the majority of the counties are designated medically underserved areas. The maldistribution problem is prevalent in urban areas, such as San Antonio where over 50 percent of medical doctors practice within two census tracts. The primary care practitioner to population ratio in Texas County has been approximately 1,400:1 for a number of years. Moreover, nearly 50 percent of the county's census tracts where the majority of Chicanos and Blacks reside have been recommended as critical health manpower shortage areas.

A major area of concern is the lack of trained Hispanic health administrators to manage and operate the various health systems and the corresponding health initiatives that have been introduced in the last few years. Too often the health centers serving Hispanics have been developed and administered by nurses and social workers who become self-trained administrators, a situation which can create problems in management as well as in service delivery. For example, at one point, the Southwest Migrant Association in San Antonio, Texas, was forced to interrupt services at a most critical time, that is, when migrants were returning from the northern agricultural fields because of some mismanagement problems. Instead of addressing the management problem, PHS appeared to be favoring the removal of the program and placing it under the auspices of other local agencies, none of which had any history of administering migrant health programs. Thus, the vital element in the development of community-based health centers, which ensures direct participation in the implementation and in the decisionmaking process by the major users of the services, was jeopardized. On the other hand, an excellent example of positive effects of consumer involvement is Su Clinica Familiar, a health center in the Rio Grande Valley of Texas, directed by a board of directors consisting of a majority of migrants, which has successfully administered over $2.5 million in grants and which has over 35,000 registered low-income residents who utilize approximately 90,000 medical encounters.

With the expansion of new health centers in rural and urban areas some failures will be experienced due to the lack of a pool of Hispanic health administrators from which the centers can draw upon. The PHS's Bureau of Community Health Services (BCHS), which has been charged with the development of these new health centers, and the Bureau of Health Manpower should work closely together to assure that failures such as have been mentioned will be avoided. BCHS could go one step further either by allowing trained health administrators to join the National Health Service Corps or by offering scholarships to individuals who are interested in health administration careers. These individuals could be placed in the now developing health centers.

2. Utilization and Access to Health Care

Discussants: Rosemarie Diaz
Francisco Velasquez

The workshop participants, upon review of the available socioeconomic data on Hispanics, concluded that the various Hispanic populations are not utilizing health care services; for example:

- -- Low income makes less money available to purchase adequate medical services.
- -- Lack of formal education leads to reduced awareness and utilization of available health care services.
- -- Crowded and inadequate housing and lack of basic services such as water and treated sewers result in greater exposure to communicable diseases.

Lack of bilingual personnel, insensitivity and/or lack of knowledge of the various cultural health care practices and beliefs have been traditionally used to focus and define the barriers to the use of health care services by Hispanics. While one cannot deny that these factors continue to play a vital role in the nonutilization of health services by Hispanics, the participants began by examining the reasons why they are considered barriers.

It is unlikely, as well as unrealistic, to think that the dominant society will become bilingual. It has always been expected that Hispanics learn and speak English if they are to survive in the United States. The fact remains, however, that one Hispanic adult in three is illiterate in English and perhaps one in ten is unable to speak the language for economic viability.

A person who speaks little or no English encounters a myriad of forms needed to "establish eligibility of need," and the situation is compounded by intimate questioning by insensitive and often officious agency workers. This is a demeaning experience which places people at the mercy of agency personnel and discourages people from applying for help until they are desperate.

The appropriate question to pose at this point is: Why do the health care providers continue to expect more from the people they service than from themselves? The attitudinal barriers established by those who dictate what is best for the people cannot and should not go unchallenged. The individuals who have those attitudes cannot and should not be allowed to think that because they have made it others who do not are seen as inferior.

For too long, the Hispanic consumer has had to accept what others thought best for them. Health planners must guard carefully against dignifying these attitudes and deciding separate and apart from the consumer whether they are sick in mind or spirit.

Those who are either in decisionmaking positions or work for agencies of the Public Health Service were urged to assume an aggressive role in eliminating some of the barriers and attitudes that for so long have permeated the health care system and which impact Hispanic populations so negatively.

During the turbulent 1960's, when many Hispanics first became involved in the improvement of the health care movement, they were perceived as agitators and militants. These perceptions were somewhat correct, since it was a time to be either angry, hostile, intimidating, demanding or even violent to get the attention of the decisionmakers. Those were the ground rules then which seemed appropriate and served to promote and facilitate many needed improvements in health care service delivery for the poor and the medically indigent.

More than a decade has passed since then. Health care challenges and issues of old remain and new ones have emerged. The need for change and improvement in the health care delivery system is greater than ever because the health needs of the Hispanic continue to be unmet. And most important of all, the ground rules for affecting change and the accompanying roles which worked then have quietly fallen by the wayside, and new strategies for change need to be identified and tested.

Moreover, community-based boards of directors are beginning to enter the business world, and grass-roots people are becoming responsible for administering hundreds of thousands of dollars. Some of these programs have met with unqualified success because input from the people being served is key. People having control about what affects them, in a policymaking role rather than an advisory role, are more likely to use those services.

One of the fundamental concepts on which primary health care rests is that the community itself must take a principal role in health care activities. Full involvement in planning, operation, delivery, and control is imperative for success. It is vital that the real health needs of a given community be understood, and that the confidence and active support of the people being served be secured. Providers must remain as accountable to the consumer served as to the funding source.

Hispanics must have a say about what affects them in a policymaking rather than in an advisory role. The workshop members were convinced that any agency, service, or program cannot be successful in a Hispanic community if the providers are not willing to deliver their serve at the people's level in a meaningful way.

Today, more than ever, government departments must continue to reinforce their commitment to consumers by providing them with an opportunity to participate on decisionmaking boards; the focal point of planning should be on the integration of services at the regional level. Help is needed to provide ongoing training programs to Hispanics rather than on a "crisis" approach. Bilingual materials, films in Spanish, with themes related to the Hispanic experience should be developed.

It is a fallacy to believe that policies affecting the health care to Hispanics can be developed three to four thousand miles away and applied uniformly across the Nation. Rather, policies must take into account regional differences as well as cultural, linguistic, and socioeconomic factors.

It is a myth that all Hispanics have the same needs and concerns. While we may be bound by the language, some cultural and ethnic characteristics, as well as some historical contexts, often our foods, value systems, priorities, and even life styles, are different; it follows that needs too are different. Hispanic representation in policymaking positions must reflect those needs and differences.

No one agency, service, or program can be successful in a Hispanic community if the providers are not willing to provide those services at the level and manner which are culturally relevant and sensitive to the various needs of that community. Assimilation is not the key to acceptance. For example, in some parts of the country, among Chicanos specifically, tortillas are part of daily life. The best tortilla makers say that the best tortillas are made with lard, a saturated fat. How are nutritionists going to convince these thousands of women that a polyunsaturated vegetable oil would be better? Many of them would not even know what the nutritionists are talking about, let alone change a custom that has been handed down for generations. Acculturation is the greatest threat to the Hispanic culture.

Providing dollars is not enough. Hispanics need all types of resources, and this includes providing services to the undocumented person or, as most commonly referred to, the "illegial alien." For too long, the attitude has been assumed that if we ignore the problem, maybe it will go away. It should be obvious that the problem has not gone away.

Workshop members felt that the need for technical assistance for the Hispanic community is great and necessary if Hispanics are to achieve the level of competence and quality in health care delivery which is sought. The concept of organized, integrated, comprehensive, primary health care systems is new to the Nation, and the fact is that there are few Hispanic groups that have the in-house capability of developing such systems. The need, therefore, is great for providing technical assistance to Hispanic groups so that they can develop and manage their own systems of health care. Specifically, some of the critically important areas identified by the workshop and which deserve technical assistance are: financial management, management information systems, board training, consumer health education and prevention, and grantsmanship and program development.

Lack of sufficient and appropriate funding may ultimately result in the termination of some of the most viable and successful programs emerging from PHS. The inconsistency in the use of funding formulas and changes from year to year, at times not applicable in some areas, the lack of tangible monitoring procedures, and mixed messages of intent create many more problems for those attempting to provide adequate health care to Hispanic populations.

The workshop participants conclude that, while much remains to be done for the health care needs of the Hispanic people, it has been clearly demonstrated that the problems affecting the use of health care by the Hispanic community can be overcome through mutual cooperation, sensitivity to the needs of the Hispanics, and the active involvement by the Hispanic community in the destiny of its health care system.

3. Research Related to Hispanic Health Status

Discussants: Esteban L. Olmedo, Ph.D.
L. Grabriel Navar, Ph.D.

The workshop participants expressed great concern for the small pool of Hispanic researchers in the various fields of health. Some of the Public Health Service (PHS) programs to train minority scientists, such as the National Institutes of Health (NIH), Biomedical Support Program (MBS), and the Minority Access to Research Careers Program (MARC), were discussed. While an intricate function of these programs is to reach out to minorities, they have not been too successful in terms of recruiting Hispanic students in proportion to their numbers in the population. Training of researchers goes beyond reaching-out programs and financial assistance. It is a profession that requires many reinforcements, support systems, role models, and strong undergraduate and graduate programs that place emphasis on the research activities, as well as concern to increase the knowledge base which will help undertand the health needs of Hispanics. Workshop participants agreed that full participation of Hispanics in the biomedical research field will come only when they have become equal participants and contributors to mainstream activities of the health agencies and society at large. Hispanic Americans are restricted by disadvantages associated with economic hardship and a nonchallenging environment. Students must be reached early if they are to be motivated toward science and research careers.

Instances were cited by the workshop participants where the literature on research findings related to Hispanics perpetuate negative stereotypes. Generally, studies have described various values, attitudes, and behaviors related to socioeconomic conditions that perpetuate problems. Such literature cannot be generalized to all Hispanic groups, as they do not describe accurately existing conditions, nor do they promote understanding of Hispanic health needs or practices per se.

Even though we recognize that Health and Human Services now includes items which will identify Hispanics on most survey instruments, there is still a lack of adequate, meaningful, reliable data on the health status and needs of Hispanics.

The research activities of the National Center for Health Statistics are designed for the collection of data on the total United States population. Due to the small number of Hispanic responses, we find severe constraints which result in the lack of specific data on their health status.

The National Center for Health Statistics and other agencies which are in the research arena should provide special grants to seek out data on Hispanics. These grants must be administered and/or include strong input by Hispanics to ensure reliable results that will be responsive to their identified needs, avoiding stereotype myths and cultural/linguistic barriers.

The present research ignores the societal structural conditions imposed by the Anglo, dominant society, which attempts to condition the life patterns of Hispanics.

4. The Health Planning Process

Discussant: Arturo Raya, Ph.D.

Federal health planning was described as particularly controversial among Hispanics because of their disproportionate low rate of participation and the possible consequences to the individual and the community of such activity.

The status of health planning was examined by focusing on barriers to participation and factors affecting the ability of Hispanics to benefit from services provided by the health care system in this country. Given that little has been written before on this topic, a review of the general literature and studies on health and Hispanics was presented and specific factors affecting participation through the planning process were identified.

While safeguards exist to ensure meaningful involvement in the planning, development, and delivery of services by this population group, guidelines and regulations are not always observed by agencies and institutions. Negative consequences can be significant to a large segment of the Nation's population who depend on the recipients of Federal grants, like health planning agencies, private and public hospitals, and outpatient facilities, to satisfy their health needs.

Attempts to correct inadequacies and injustices in the planning and delivery of health services as it relates to the Hispanic population have had limited success. The Federal Government has not promoted action plans aggressively and has not monitored compliance issues in a comprehensive way. Reform is needed to address adequately the special problems of Hispanic Americans. Planning, development, delivery, and related activities must be conducted in the way most appropriate to Hispanic Americans, who comprise the second largest minority group in this Nation.

The enactment of the National Health Planning and Resource Development Act of 1974 provided Hispanics a renewed hope and an avenue for meaningful participation in the important area of health planning. Heretofore, the absence of Hispanics in the health planning process had resulted in a barrier impeding the programmatic responses which might have increased our utilization of existing services. P.L. 94-464 offers very positive implications which should lead to the development of service systems responsive to the real needs of Hispanics.

The South Texas Health Consumers Association's involvement with the two HSA's in South Texas, for example, has produced good results. The Association has been instrumental in securing significant input into the planning processes developed by Camino Real. As the only organized health consumer group in the State, the Association is well regarded and respected by the local planners. In fact, the Association cosponsored with the HSA 14 health consumer planning seminars within the area. Further, the Association has responded with concrete suggestions, most of which have been accepted, endorsed, and incorporated into the 5-year Health Systems Plan and the Annual Implementation Plan of the Camino Real HSA.

Issues raised in this workshop included the inadequate Hispanic participation in health planning, and the many regulations of the Federal Government which prevent meaningful involvement. Although the social and cultural differences of Hispanics are clear, and how they should be taken into account seems fairly obvious, other factors intervene which make the process very difficult.

A general feeling was expressed that the increasing specificity and rigidity of regulations tend to exert a sophisticated form of discrimination directed against those individuals and groups unaccustomed to dealing with such processes.

The plight of Hispanics was defined as a combination of cultural factors and the problems of the poor. It is difficult to achieve involvement in health planning by poor populations who have neither the time nor the knowledge to become meaningfully engaged in planning.

Additional discussion focused on some of the major problems of working through the health planning system to address the problems of Hispanics.

5. Hispanic Health Statistics

Discussant: Carlos Vallbona, M.D.

This workshop devoted time to the discussion of the relationship between Hispanic health needs and health research activities with emphasis on the serious gaps which exist on health statistics and research on Hispanics.

The workshop participants identified three major types of statistics and research needs related to Hispanic populations. Although progress is being made, inadequacies in each of these areas constrain the development and implementation of realistic policies and programs to protect and improve the health status of Hispanics.

There is inadequate basic descriptive data on Hispanic health status information, attitudes, behavior, and health care service utilization. The term "Hispanic" serves as a label for a variety of subgroups with a variety of needs, and little data exists on differences in the health needs of Mexican, Cuban, Puerto Rican, Spanish, and other Hispanic American subgroups. There is some national sample data, but no figures are available for each subgroup. The National Center for Health Statistics (NCHS) is considering whether estimates on subgroup characterists can be developed by combining data from several years of survey data, but final reports on this proposal are not available.

Efforts to secure Hispanic data from birth and death certificates were discussed. While States are responsible for collecting vital statistics, only about half of the States have done so, and litle attention has been focused on improving data collection efforts on minority groups at the State level.

There is a dearth of research on the effectiveness of different srategies for promoting and improving the health status of Hispanics. The role of home nursing, health education, and the impact of bilingual health personnel were specifically mentioned as subjects for research, as was the need for the study of the roles that religious attitudes and beliefs in folk medicine play in meeting the health needs of these population groups.

A third area of concern involved manpower development issues. Special interest was expressed in developing effective strategies to recruit Hispanics into the various health professions and the need for role models and health leader/advocates within the Hispanic communities, as well as the need to identify the special concerns that impact Hispanic health workers in the areas of health education and cost containment.

Workshop participants emphasized the point that research and data collection should be guided by sound conceptual and theoretical framwworks. One key theoretical question concerns the relative impact of economic factors, as opposed to cultural ones, on Hispanic health status, health problems and their resolution. Although the possible influence of culture (for instance, religious attitudes and beliefs in folk medicine within some Hispanic groups) was not discounted, the impact of poverty was generally regarded as dominant. It is quite possible that the health status of upper- and middle-income Hispanics differs little from their Anglo counterparts, whereas lower-income Hispanics appear to suffer health problems with particular intensity.

RECOMMENDATIONS

1. Health Statistics
2. Health Manpower
3. Health Planning
4. Health Care Utilization
5. Health Research
6. Community and Migrant Health Centers

RECOMMENDATIONS ON SPECIFIC HEALTH PROGRAM NEEDS

1. Health Statistics

Collect Hispanic group specific data and conduct empirical research to use in setting goals and programs that have a positive impact upon the health problems of the Hispanic community.

Develop strategies for the dissemination of the statistical and research data obtained by the National Center for Health Statistics (NCHS) and the National Center for Health Services Research (NCHSR).

Establish a Hispanic Advisory Council for the NCHS and NCHSR. Such a council would be an important source of information to guide program priorities.

Strengthen affirmative action programs and encourage them to hire Hispanic staff.

2. Health Manpower

Ensure that guidelines and plans to implement health manpower programs address the Hispanic health manpower development needs.

Use special projects and incentive grants to promote admission of Hispanic students to educational institutions and to explore new ways to identify minority applicants with potential to enter and complete a health professional career.

Address legislatively the need to give priority to minority students entering the health care field. Provide rewards to encourage institutions to participate actively in this effort.

Use appropriate special project support to prepare students to relate to patients from different cultures and backgrounds.

States receiving Federal funds should require an accountability by age, sex, and race.

Encourage and pressure educational institutions with allied health profession programs into developing strong affirmative action programs.

Encourage the use of Hispanic role models, especially at the undergraduate level. Identify also nonminority role models who have acquired the necessary sensitivity and who have in many cases learned to speak the language.

Beginning with the ninth grade, support programs to expose disadvantaged minorities and students to scientific and health careers. Other programs in the Office of Education, such as Head Start and Upward Bound, could be used to complement these efforts.

Encourage science teachers and counselors to increase their effectiveness in motivating and preparing Hispanic students, sponsoring visiting scientists to speak to high school students, increasing the visibility of Hispanic scientists, and highlighting biomedical science as a career option for Hispanic Americans. Make a concerted effort to draw more U.S.-born Hispanics into biomedical science and to provide the full range of options for training and further professional development.

3. Health Planning

The Department of Health and Human Services (DHHS) should develop a well-defined policy regarding the health needs of Hispanic Americans and assign a high priority to health planning, resource development, and research for Spanish-speaking communities across the country. Health planning mechanisms should be encouraged and allowed to focus their resources more specifically on Hispanics and other economically disadvantaged population groups.

The continuing and pervasive problems of overly restrictive regulations in the health delivery systems should be examined to determine their negative impact on the poor.

The Federal Government must rectify the underrepresentation of Hispanics on boards, task forces, and advisory bodies of Federal agencies such as the National Institutes of Health (NIH), the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), and the National Center for Health Statistics (NCHS).

The involvement of consumers in the health planning process should be facilitated through responsive training and reimbursement policies.

The overly rigid distinctions between providers and consumers used by the Health Services Administration (HSA) to appoint public bodies must be corrected.

4. Health Care Utilization

DHHS should develop an effective coordinative mechanism to eliminate fragmentation and duplication of health programs affecting Hispanic Americans, and direct Federal health agency administrators and Regional Health Administrators to expedite integration of services and to monitor agency programs' and grantee organizations' effectiveness with regard to the Spanish-speaking communities.

DHHS should establish an effective mechanism to maintain continuous dialogue with the Hispanic community to assure awareness and understanding of existing and anticipated needs.

Health programs in areas with a high Hispanic population should be designed according to the existing needs and with the involvement of the population.

Technical assistance must be provided to Hispanic groups so that they can develop and manage their own systems of care.

Health services must be delivered in a meaningful way at the people's cultural and linguistic level.

Special attention must be given to prevention activities among Hispanic Americans due to the fact that unfavorable socioeconomic conditions experienced by these groups make them a high-risk population.

5. Health Research

DHHS should develop systematic procedures for the collection, retrieval, and analysis of information and data on the health status and needs of Hispanic Americans; establish a task force as soon as possible to identify definitional and methodological problems; and prepare a plan to gather the necessary data.

Existing health research centers should be made accessible to Hispanics and be included in the studies conducted by such centers.

Efforts should be made to explore the opportunities for establishing new research centers in areas with large identifiable populations of Hispanic Americans to increase the benefits that Hispanics derive from research activities.

A special effort should be made to convey information to Hispanic Americans resulting from research conducted in unique settings, as for instance in Central and South America.

Continuing support should be given to existing NIH and Federal minority programs to further their success in preparing larger numbers of undergraduate students for doctoral training in the biomedical sciences.

6. Community and Migrant Health Centers

Support the concept and the future development of Community Health Centers (CHC) and Migrant Health Centers (MHC) for the Chicanos in the Southwest with consideration of the following factors:

-- That they be community-based and consumer-controlled ("consumer" meaning users or potential users of the services of the center).

-- That they provide a set of comprehensive primary health services with the necessary support services, such as health education, transportation, social services, mental health services, home health services, nutrition, dietary and outreach services.

-- That adequate facilities be provided in the defined or determined services area, and that the delivery of services out of houses and substandard facilities be prevented.

-- That adequate equipment be made available to help health centers that do not get approval from the Region to buy equipment to provide in-house services (i.e., laboratory) and must purchase the services outside the center at a higher cost per service.

-- That (a) Waivers for Certificate of Need be removed from the political and medical profession influence, which is usually opposed to changing the method of delivery of health service from the fee for services to consumer-controlled systems of care; (b) the high cost of attorney's fees and consultants to obtain a Certificate of Need be eliminated; and (c) the long process to get a Certificate of Need be shortened.

-- That technical assistance be provided by organizations such as Federations of Health Centers or regional or national associations only if they have input from the recipients of the technical assistance.

-- That priority be given to the expansion of CHC's and MHC's presently in operation as opposed to creating new ones.

-- That centers be allowed to develop the capability to provide in-patient services, thus providing the CHC and/or MHC with incentives to control in-patient care and leading to cost containment and control of the inflation rate of the health industry.

-- That maternal and child health, family planning, adolescent health, improved pregnancy outcome, immunization, and mental health services be included in the CHC and MHC benefits package to make the services of these centers more comprehensive.

-- That the CHC and MHC be allowed, at the discretion of the center, to convert to a prepaid mechanism of health care reimbursement.

-- That, in order to prevent duplication of services, monies be provided to inter-city initiatives for the presently established CHC's and MHC's and not local governments where CHC's and MHC's exist.

-- That these centers be developed with the commitment and understanding that will become a major delivery system of primary health service.

-- That these centers be located in the areas accessible to the residence of the users.

-- That a sensitive Regional Health administrator, who is empathetic to the CHC and MHC concept and who will provide leadership, direction, and resources to the future development of these systems, be appointed.

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